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Welcome
To Our Practice!

Patient Information

RETURN THIS PAGE TO THE RECEPTIONIST WHEN FINISHED. PLEASE PRINT CLEARLY.

Name_____ I prefer to be called (nickname) _____
Address _____
City_____ State_____ Zip_____
Home Phone (_____) _____ Cell Phone (_____) _____
I prefer calls at: □Home □ Work □ Cell Email Address: _____

☼ Emergency Contact _____ Phone Number (_____) _____

Employment Status □Full Time □Part Time □Retired □Student □Other
Place of Employment _____ Work Phone (_____) _____ Ext _____
Sex: M or F Birthdate ____/____/_____ Social Security #_____-____-_____
Martial Status □ Married □ Single □ Divorced □ Separated □ Widowed
If a minor: Mother's name _____ Father's name _____
Mother's work# (_____) _____ Father's work# (_____) _____

Whom may we thank for referring you? _____ □Family □Friend □Co-worker
□Website □Phone Book □Other
PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT:_____
Date completed ___/___/_____ Signature _____ □Patient □Parent □Guardian

PLEASE FILL OUT THE FOLLOWING INFORMATION IF YOU HAVE DENTAL INSURANCE:

Primary Insurance

Name of insured: _____ Social Security #: ____-____-_____ Date of birth:___/___/_____
Place of Employment: _____ Insurance Company: _____
Address:_____ Address:_____
Telephone (_____) _____ Group number _____

Secondary Insurance

Name of insured: _____ Social Security #: ____-____-_____ Date of birth:___/___/_____
Place of Employment: _____ Insurance Company: _____
Address:_____ Address:_____
Telephone (_____) _____ Group number _____

Medical History

Note: MEDICATIONS and ALLERGIES CAN BE LISTED IN FULL ON THE FOLLOWING SHEET

Researchers are continuing to shed light on the relationship between oral and systemic (overall) health. While our dental team is responsible primarily for the areas in and around the mouth, it is very important that we know your health history. Your health conditions and the medications that you are currently taking may impact the dental treatment that you receive. Thanks for answering these important questions.

Have you seen a physician within the last year? □Yes □No

CONDITIONS: IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS **PLEASE CIRCLE IT:**

Anemia	Cold Sores/Blisters	High Blood Pressure	Sinus Problems
Angina	Congenital Heart Defect	HIV/AIDS	Stroke
Arthritis	Diabetes	Hypoglycemia	Thyroid Disease
Artificial Heart Valve	Drug Addiction	Kidney Disease	Tuberculosis (TB)
Artificial Joint:	Emphysema	Leukemia	Ulcers
Knee or Hip?	Fainting Spells	Liver Disease	Unexplained Weight Loss
Year? _____	GERD/GI Issues	Osteoporosis	Venereal Diseases
Asthma	Headaches	Psychiatric Care	Other (explainc below)
Bleeding Problems	Heart Attack	Radiation Treatment	
Cancer/Chemotherapy	Hepatitis A,B or C	Seizures	

Other major medical conditions? □Yes □No If so, explain: _____

Do you smoke or chew tobacco? □Yes □No If so, how much? _____

Do you require antibiotics prior to dental appointments? □Yes □No Reason? _____

Have you ever had radiation/chemo treatment to the head or neck? □Yes □No If so, when? _____

Have you ever had an allergic reaction to latex? □Yes □No

Have you taken Bisphosphonates like Boniva, Fosamax or Reclast? □Yes □No

Women: Are you pregnant? □Yes □No

Are you nursing? □Yes □No

Are you taking oral contraceptives? □Yes □No

NOTICE OF PRIVACY PRACTICES and DESIGNATION OF OTHER PARTIES

In compliance with the HIPAA (Health Insurance Portability and Accountability Act) laws regarding patient privacy of health information**, we will be able to speak with only YOU, the patient**, regarding appointments, treatment or any aspect of your dental care. However, if you wish to designate another person to schedule appointments and be part of your dental health care, please indicate that person below and sign for verification.

Please be aware that a full copy of our Notice of Privacy Practices is available upon request

Designated Person _____ Relationship: □Parent □Spouse □Guardian □Other

Patient Signature _____ Date ____/____/_____

□ I do not wish to designate another party

Medical Information/Medications/Allergies

*a staff member will help you complete the top section of this form

ALERTS	ALLERGIES	ANTIBIOTICS (pre-medication needed, dose)

Name _____ DOB ____ /____ /_____ Age _____

Current Physician(s): Please list all doctors/specialists with phone numbers if known

Doctor's Name:	Specialty:	Telephone Number:
		(_____) _____
		(_____) _____
		(_____) _____
		(_____) _____

Medications, Conditions and Dosages

*For convenience, you may attach a printed list of medications

Medication:	To Treat This Condition:	Dosage:

For Office Use Only

Date:	Medical History Updates:	Date:	Medical History Updates:

Dental History

What is the reason for your visit today?

_____

Who was your previous dentist and how long has it been since your last appointment?

_____

Have you ever had a set of full mouth x-rays taken? □Yes □No If so, what year? _____

Are you having problems or discomfort at this time? _____

Are you happy with the way that you are able to chew your food? _____

Are you happy with the way that your teeth look? _____

Are you able to smile confidently? _____

Please check YES or NO to the following. If yes, please briefly explain:

Do your gums bleed? □Yes □No _____

Have you been told that you have periodontal disease? □Yes □No _____

Has anyone showed you the correct way to brush your teeth? □Yes □No _____

Do your teeth hurt when you chew? □Yes □No _____

Do you clench or grind your teeth? □Yes □No _____

Do you find your jaw muscles get sore and tired? □Yes □No _____

Do you get frequent headaches or earaches? □Yes □No _____

Does your jaw click or pop when you open wide? □Yes □No _____

Are your teeth sensitive to hot, cold or sweets? □Yes □No _____

Do you experience dry mouth? □Yes □No _____

Do you snore heavily? □Yes □No _____

Do you have unhealed injuries, sore areas, or growths in or around your mouth? □Yes □No

_____

Have you ever had prolonged bleeding after a dental procedure in the past? □Yes □No

_____

Have you ever had a bad dental experience or are you fearful of having dental treatment? Please explain:

_____

_____

Is there any other issue that you feel we should know about? □Yes □No

_____

Dental Insurance and Our Office Perspective

Our Prospective: If you have dental insurance we will work hard to help you receive the maximum benefits allowed by your plan. This entails composing pre-treatment estimates, submitting claims, making calls to carriers and even writing letters on our patients' behalf. **These efforts are performed as a courtesy to our patients.**

We will strive to recommend appropriate treatment or services with your dental health, your overall health and your best interest in mind.

Some important ideas to keep in mind:

1. **It is important to take an active role, both as a patient and as a consumer, in order to maximize the benefits and to understand the details of your particular plan.**
2. Your insurance is a contract between you, your employer and the insurance company. We are not part of this contract.
3. There are so many insurance providers and plans - each company has their own options.
4. Most insurance companies have deductibles which you are responsible to pay.
5. Most insurance companies only pay a percentage of the cost of treatment (i.e. 100% of preventative, 80% restorative, 50% crown and bridge, etc).
6. Not all recommended services are a covered benefit in every contract.
7. The remainder or uncovered portion is your responsibility to pay.
8. Most insurance companies have clauses, exclusions, yearly maximums, categories of coverage and waiting periods**: These realities often make understanding their practices very difficult. These clauses will affect your benefits at any given time.**

Please ask us if you have any questions regarding the above information.
Please ask us if you have general questions about your coverage – we will try our best to answer them.
Please ask us…we will try to help you in any way we can.

Please initial and sign where indicated:

I have read the above information and I have had a chance to ask questions _____ ← initial

I UNDERSTAND THAT I AM FINIANCIALLY RESPONIBLE FOR THE CHARGES ON MY ACCOUNT _____ ← initial

SIGNATURE_____ DATE ___/___/_____

Payment and Financial Arrangements

This practice depends upon reimbursement from patients for the costs incurred in providing care; we cannot render services on the assumption that fees will be paid by your insurance carrier. Payment for services is due at the time that services are rendered.

We will strive to help our patients make timely payments. Here are some ways we can help:

1. **As of January 1, 2013** we will offer a **5% fee reduction if payment-in-full is received on the date that services are rendered**. Payment must be made by cash, check or the following major credit cards.

2. **You may give us authorization to make automatic deductions from a line-of-credit or credit card.** These deductions must occur weekly, bi-monthly or monthly and the terms must be arranged so that the outstanding balance is paid in a reasonable amount of time.

3. We accept **CareCredit**, which offers interest-free financing if you qualify.

CareCredit®
Patient Payment Plans

4. **In some cases**, we will work with you to make **financial arrangements** to pay for proposed treatment and services.

Broken Appointment Policy

We reserve appointment times to properly provide services and treatment in a way that benefits you and our other patients. We expect our patients to keep their appointments, unless a real emergency arises. If you are unable to make your appointment, please contact us immediately. We will do our best to accommodate you and to find a time that best suits your schedule.

If you cancel or break an appointment without giving 24 hours notice, you may be charged a fee. This fee will vary based on the length of the appointment that was broken. This office reserves the right to reduce or remove this fee.

I UNDERSTAND THAT A FEE MAY BE CHARGED IF I CANCEL OR BREAK AN APPOINTMENT WITHOUT GIVING 24 HOURS NOTICE_____ ← initial

SIGNATURE_____ DATE ___/___/_____