WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

- **Patient Information**

Date_____ Home Phone (__)_____ Cell Phone(__)_____

Name_____ SS/HIC/PATIENT ID #_____

Address_____E-mail_____

City_____State _____Zip_____

Sex ( )M ( )F Age_____ Birthdate _____

( ) Married ( ) Widowed ( ) Single ( ) Separated ( ) Divorced ( ) Partnered ( ) Minor

Patient Employer/School _____ Occupation _____

Employer Address_____ Employer Phone(__)_____

Whom may we thank for referring you? _____

In case of emergency who should be notified?_____ Phone (__)_____

- **Primary Insurance**

Person Responsible for Account_____

Relation to patient_____Birthdate_____ID#/Soc.Sec.#_____

Address(if different from patient's)_____ Phone (__)_____

City_____ State_____ Zip _____

Person Responsible Employed By_____ Insurance Company_____

Group #_____ Subscriber # _____

- **Additional Insurance**

Subscriber Name_____ Relation to Patient_____ Birthdate_____

Address(if different from patient's)_____ Phone(__)_____

City_____ State_____ Zip_____

Subscriber Employed By_____ Insurance Company_____

Soc. Sec. #_____Subscriber #_____ Group #_____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Please mark all that apply

Are you under a physician's care now? ( ) If yes, please explain:_____

Have you ever been hospitalized or had a major operation? ( ) If yes, please explain:_____

Have you ever had a serious head or neck injury? ( ) If yes, please explain:_____

Are you taking any medications, pills, or drugs? ( ) If yes, pleas explain:_____

Do you take, or have you taken, Phen-Fen or Redux? ( ) _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ( ) _____Are you on a special diet? ( ) Do you use tobacco? ( ) Do you use controlled substances? ( )

Women: Are you
Pregnant/Trying to get pregnant? ( ) Taking oral contraceptives? ( ) Nursing? ( )

Are you allergic to any of the following?
( ) Aspirin ( ) Penicillin ( ) Codeine ( )Local Anesthetics ( )Acrylic ( )Metal ( )Latex ( )Sulfa Drugs ( )Other If yes please explain:_____

Do you have, or have you had, any of the following:

( )Aids/HIV positive	( )Cortisone Medicine	( )Hemophilia	( )Radiation Treatments
( )Alzheimer's Disease	( )Diabetes	( )Hepatitis A	( )Recent Weight Loss
( )Anaphylaxis	( )Drug Addiction	( )Hepatitis B or C	( )Renal Dialysis
( )Anemia	( )Easily Winded	( )Herpes	( )Rheumatic Fever
( )Angina	( )Emphysema	( )High Blood Pressure	( )Rheumatism
( )Arthritis/Gout	( )Epilepsy or Seizures	( )High Cholesterol	( )Scarlet Fever
( )Artificial Heart Valve	( )Excessive Bleeding	( )Hives or Rash	( )Shingles
( )Artificial Joint	( )Excessive Thirst	( )Hypoglycemia	( )Sickle Cell Disease
( )Asthma	( )Fainting Spells/Dizziness	( )Irregular Heartbeat	( )Sinus Trouble
( )Blood Disease	( )Frequent Cough	( )Kidney Problems	( )Spina Bifida
( )Blood Transfusion	( )Frequent Diarrhea	( )Leukemia	( )Stomach/Intestinal Disease
( )Breathing Problem	( )Frequent Headaches	( )Liver Disease	( )Stroke
( )Bruise Easily	( )Genital Herpes	( )Low Blood Pressure	( )Swelling of Limbs
( )Cancer	( )Glaucoma	( )Lung Disease	( )Thyroid Disease
( )Chemotherapy	( )Hay Fever	( )Mitral Valve Prolapse	( )Tonsillitis
( )Chest Pains	( )Heart Attack/Failure	( ) Osteoporosis	( )Tuberculosis
( )Cold Sores/Fever Blisters	( )Heart Murmur	( )Pain in Jaw Joints	( )Tumors or Growths
( )Congenital Heart Disorder	( )Heart Pacemaker	( )Parathyroid Disease	( )Ulcers
( )Convulsions	( )Heart Trouble/Disease	( )Psychiatric Care	( )Venereal Disease

Have you ever had any serious illness not listed above?_____

DENTAL HISTORY

Reason for Today's Visit?_____ Date of last dental care?_____

Former Dentist?_____ Date of last dental X-rays?_____

Please check if you have had problems with any of the following:

( )Bad Breath	( )Grinding Teeth	( )Sensitivity to Hot
( )Bleeding Gums	( )Loose Teeth or Broken Fillings	( )Sensitivity to Sweets
( )Clicking or Popping Jaw	( )Periodontal Treatment	( )Sensitivity when biting
( )Food Collection Between Teeth	( )Sensitivity to Cold	( )Sores or growths in your mouth

How often do you floss?_____How often do you brush?_____

To the best to of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Gaurdian:_____

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from our patients for the cost incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any services performed without previous financial arrangements must be paid for at the time of services rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient, and that he or she is personally responsible for the payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1 ¾% per month (21% per annum) on the unpaid balance will be assessed on all accounts exceeding ninety (90) days from date of service unless previously written financial arrangements are made.

In consideration for the professional services rendered to me, or at my request to my minor child or ward, by the dentist, I agree to pay the fees charged for the dental service provided by the dentist or his assignee at the time services are rendered, or within five (5) days of billing if credit shall be extended. I agree to pay the remaining balance plus reasonable attorney, court cost and a collection agency commission of 33.3% of the delinquent balance if the account is assigned to a collection agency or attorney. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, interest charges assessed, etc., to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at my home or at my workplace to discuss matters related to this form. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior arrangements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his assignees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or in paper form to my insurance carrier or any related entities that requires such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

Signature:_____ **Date:**_____

Consent to the Use and Disclosure of Health Information

for Treatment, payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Signature of Patient or Legal Representative:

Signature:_____

Date:_____

Cancellation and Missed Appointment Policy

We know that your time is valuable and make every attempt to be on time for your appointment. We ask that you respect our time as well. If you cannot keep your scheduled appointment, we need at least 48 hours notice. Cancellations with less than 48 hours notice are subject to a cancellation fee appropriate to the time reserved for your appointment. The minimum fee that would be charged is $75.00. No shows and repeat cancellations will force us to place you on a short notice list. Of course car problems, sickness and family emergencies do happen- and we understand. But the cost of needlessly missed appointment time is borne by all- in overhead, time and energy and eventually, in patient fees.

Signature:_____