Patient Information

Name: ____________________ Age______ Sex______ Date of Birth:____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Minor Social Security# ____________________

Address: ____________________City____________________State______Zip_________

Home Phone #:____________________Cell Phone #:____________________Work Phone #:____________________

Email:____________________ (For appointment reminders and office information)

How did you hear about our office? ____________________

Responsible Party

Name: ____________________ Date of Birth____________________

Address: ____________________City____________________State______Zip_________

Home Phone #:____________________Cell Phone #:____________________ Email: ____________________

Employer ____________________Social Security #____________________Relationship to patient________________

Emergency contact: Name____________________ Relationship to patient ________________Phone________________

Insurance information

☐ Not covered by dental insurance

Primary Insurance Co.____________________ SS#: ____________________ Employer____________________

Primary Ins. Policy Holder____________________ Policy Holder's Birthday ____________________

Covered by a secondary insurance? ☐ Yes ☐ No

Secondary insurance Co. ____________________ SS# ____________________ Employer____________________

Secondary Ins. Policy Holder____________________ Policy Holder's Birthday ____________________

Release of Information

In accordance to the HIPPA Privacy Act, Please note that for all patients over the age of 18, we are unable to release **any** information to **anyone** unless given written authorization. Please list the name(s) of the person(s) you allow us to share your information.

Name:____________________ Relationship to patient: ____________________phone#____________________

Name:____________________ Relationship to patient: ____________________phone#____________________

Consent for services

I authorize the doctor or designated staff, to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me. I assign all dental insurance benefits to which I am entitled to the doctor. I also authorize this practice to submit claim forms and receive payment directly from the insurance company. I authorize the practice to release treatment records/x-rays or any other information needed to my insurance company, as necessary/requested. I agree to be responsible for payment of all services rendered on myself and on my dependents. I agree to be responsible for any unpaid claims.

Patient/ Parent or Guardian Signature ____________________ Date:____________________

Medical History

Do you have or have you had any of the following? Please answer Yes (Y) or NO (N)

❑Y ❑N Abnormal bleeding after extractions, surgery,
❑Y ❑N AIDS or HIV positive
❑Y ❑N Allergies or hives
❑Y ❑N Alcohol use/addiction
❑Y ❑N Anemia
❑Y ❑N Arthritis
❑Y ❑N Artificial Joints or valve
❑Y ❑N Asthma
❑Y ❑N Autism
❑Y ❑N Bleeding Disorders
❑Y ❑N Blood transfusion
❑Y ❑N Cancer or tumor
❑Y ❑N Chemotherapy
❑Y ❑N Convulsions
❑Y ❑N Diabetes
❑Y ❑N Drug use/addiction
❑Y ❑N Dizziness /Fainting Spells
❑Y ❑N Epilepsy/Seizures
❑Y ❑N Emphysema
❑Y ❑N Glaucoma
❑Y ❑N Heart ailment or angina
❑Y ❑N Heart murmur, mitral valve prolapse, heart defect
❑Y ❑N High or Low blood pressure
❑Y ❑N Heart attack
❑Y ❑N Hemophilia
❑Y ❑N Hepatitis A, B or C
❑Y ❑N Herpes or cold sores
❑Y ❑N Hay fever or sinus trouble
❑Y ❑N Head Injuries
❑Y ❑N Liver disease
❑Y ❑N Lung problems
❑Y ❑N Kidney disease
❑Y ❑N Mental Disorders
❑Y ❑N Migraine or frequent headaches
❑Y ❑N Nervous Disorders
❑Y ❑N Pacemaker
❑Y ❑N Psychiatric treatment
❑Y ❑N Radiation treatments
❑Y ❑N Rheumatic fever
❑Y ❑N Rheumatism
❑Y ❑N Respiratory problems
❑Y ❑N Stomach/ Intestinal Problems
❑Y ❑N Stroke
❑Y ❑N Sexually transmitted Disease
❑Y ❑N Smoking/Tobacco Use
❑Y ❑N Tuberculosis
❑Y ❑N Ulcers
❑Y ❑N Yellow Jaundice

Allergies

❑Y ❑N Acrylic
❑Y ❑N Aspirin
❑Y ❑N Amoxicillin
❑Y ❑N Codeine
❑Y ❑N Erythromycin
❑Y ❑N Local Anesthetic
❑Y ❑N Latex
❑Y ❑N Penicillin
❑Y ❑N Sulfa Drugs
❑Y ❑N Seasonal
❑Y ❑N Other___________________
____

If you are a Female

❑Y ❑N Pregnant
❑Y ❑N Nursing
❑Y ❑N Taking Birth Control
❑Y ❑N Taking Hormone Medication
OB/GYN Info:______________________
____

Please list any current medications:____
____Date of last exam__________________
Do you have any current health problems not listed above? If yes, list______________________
____
Are you currently being treated by a physician? Why?_________________________________
Physicians name, address and phone number_______________________________________

Dental History

Name of previous dentist ____Date of last visit__________

Do your gums Bleed when brushing and flossing? ❑YES ❑NO
Are your teeth sensitive to hot or cold? ❑YES ❑NO
Are your teeth sensitive to sweet or when biting? ❑YES ❑NO
Do you have any sores/growths on/near your mouth? ❑YES ❑NO
Do you have/had jaw pain or injuries? ❑YES ❑NO
Do you clench or grind your teeth? ❑YES ❑NO
Do you have/wear dentures, partials or implants? ❑YES ❑NO
Are you happy with your smile? ❑YES ❑NO

Financial Policy

This statement is to inform you of our financial policy. Our main goal is to provide you with the best dental care, and that you receive the optimal treatments needed to restore and maintain your dental health. For this reason we have formulated the following financial policy, in order to continue providing you excellent service. We ask you to please carefully read and sign our financial policy.

Payment for services is due at the time that the services are provided. For your convenience, we accept cash, check, and most major credit cards (Visa, Master Card and Discover). We also accept Care Credit financing (please ask our staff for further details).

If you have dental insurance, we welcome most insurance plans, meaning that we will assist you in processing your insurance claims. Not all services are covered in all policies. Patients are ultimately responsible for any non-covered services and/or any balance not covered by your insurance policy. If your insurance company does not pay your balance due in full within 60 days, we will require you to pay for the remaining balance.

Returned checks will have an additional fee of $25 added to the check amount. Outstanding balances older than 90 days may be subject to collection fees and finance charges at 1.5% per month (18% annually).

We kindly request that our patients give us at least 48-hour notice for all cancelations, you may be charged for a missed appointment. If you need to reschedule or cancel an appointment, please give us a call as soon as possible.

If you have any questions regarding our financial policy, please do not hesitate to ask. We are committed to providing you with the most positive experience in dental care.

_____________________________ _________________________________ __________________

Patient/ Parent or Guardian Signature Relationship to patient Date

Acknowledgment of Receipt of HIPPA Notice of Privacy Practices

I acknowledge that I have reviewed/received a copy of this office's HIPPA Notice of Privacy Practices. I understand that I have the right to request a copy of this office's Notice of Privacy Practices at any time.

_______________________________ _______________________________ __________________

Patient/ Parent or Guardian Signature Relationship to patient Date