



PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First M MM DD YY
 Male Female Married Single Child Other _____
 Social Security #: _____ Birth Date: _____ E-Mail: _____
MM DD YY
 Phone (Home): _____ Mobile/Cell: _____ Work: _____ Ext. _____
 In case of Emergency, contact Name: _____ Phone: _____ Relation: _____
First Last
 Address: _____
Street Apartment #

City State Zip Code

RESPONSIBLE PARTY INFORMATION

Name: _____ Social Security #: _____
Last First M
 Sex: _____ Date of Birth: _____ Relationship to Patient: _____
MM DD YY
 Address: _____
Street Apartment #

City State Zip Code

INSURANCE INFORMATION

PRIMARY COVERAGE

Name of Insured: _____ Social Security #: _____
Last First M
 Sex: _____ Date of Birth: _____ Relationship to Patient: _____
MM DD YY
 Insured's Employer Name: _____ Group # _____
 Insurance Plan Name and Telephone: _____

SECONDARY COVERAGE

Name of Insured: _____ Social Security #: _____
Last First M
 Sex: _____ Date of Birth: _____ Relationship to Patient: _____
MM DD YY
 Insured's Employer Name: _____ Group # _____
 Insurance Plan Name and Telephone: _____

REFERRAL INFORMATION

How did you hear about our practice?

- Doctor Referral Friend/Relative Radio/TV Ad Mailer Internet Search
 Insurance Other: _____

Name of referring person: _____
Last First M



HEALTH INFORMATION

Previous Dentist: _____

Date of Last Dental Visit: _____ Date of Last X-rays: _____

Reason for This Visit: _____

Have you ever had any of the following? Please check all that apply:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tobacco Usage |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Growths | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mitral Valve Prolapse (MVP) | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Defect | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Antibiotics Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | Due: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Prescribed Weight Loss Med. | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Other Anesthetic Allergy |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> HIV | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatism | OTHER: |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> _____ |
| | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> _____ |

Have you ever had any complications following dental treatment(s)? Yes No

If yes, please explain: _____

Have you ever been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

Are you now under the care of a physician? Yes No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

Are you taking any medications? Please List: _____

What is your primary source of water? Well County

Do you pre-medicate for dental appointments? Yes No If so, why: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment.

SIGNATURE _____

Date: _____ MM DD YY



SMILE EVALUATION

Is there anything about your smile you do not like? Yes No

I would like to change (please circle):

Whiteness Spaces: Front/Back Crooked Old Fillings Tooth: Shape/Size/Length

Other Dental Problems: _____

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I authorize payment of dental benefits to the named provider for professional services rendered and the release of any clinical records and x-rays necessary to process dental claims.

FINANCIAL POLICY & CONSENT FOR SERVICES

Dental Insurance: We will submit insurance claims as a courtesy on your behalf and utilize your benefits towards treatment rendered. We make every attempt to determine your insurance plan benefits. However, any treatments rendered that is not covered by your insurance plan due to limitations and/or exclusions will be your financial responsibility.

Co-payments and Deductibles: All co-payments and deductibles are expected at the time of service and it is a breach-of-contract with your insurance provider for them to be waived.

Financial Arrangements: As a condition of your treatment, financial arrangements must be made in advance. Complete payment must be made upon the completion of services. We do not offer a "payment plan" that will extend beyond the number of visits needed for your treatment. However, in order to make your treatment affordable, we will help you to arrange outside financing, if needed, prior to the initiation of treatment.

Digital Images and Radiographs: Photographs and images taken during treatment may be shown to other patients and doctors for educational purposes only.

Cancellation Policy: Your appointment time has been reserved for you. We understand that emergencies arise. However, in non-emergency situations, we expect 48-hour notification for cancelled appointments. Any non-emergency cancellation less than 48 hours prior to the appointment will be subject to a \$25.00 cancellation fee.

SIGNATURE Date: _____
MM DD YY

ACKNOWLEDGEMENT OF HIPPA POLICY NOTICE

I have had the opportunity to review the Notice of Privacy Practices.

SIGNATURE Date: _____
MM DD YY