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Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Soc.Sec.# _____

Preferred appointment times:
☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Morning ☐ Afternoon

Whom may we thank for referring you to our practice?
☐ Radio ☐ Dental Office ☐ Family/Friends ☐ Internet
☐ Work ☐ Other (name below):

Name of person, office, or other source referring you to our practice:

Referral Name:* _____

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Phone Number: _____

Secondary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Phone Number: _____

Patient Medical History

Please check all that apply

☐ ***I understand that by not selecting a medical condition on this list it means that it does not apply to me.**

☐ * Cephalexin Allergy	☐ *Amoxicillin Allergy	☐ *BISPHOSPHONATE	☐ *Erythromycin Allerg
☐ *Penicillin Allergy	☐ *Sulfa Allergy	☐ A.I.D.S.	☐ AFIB
☐ ALLERGY SEPTRE ANTIBIOTIC	☐ Allergies	☐ Amoxicillin Allergy	☐ Anemia
☐ Anxiety / Depression	☐ Arthritis	☐ Artificial Joints	☐ Aspirin
☐ Asprin	☐ Asthma	☐ Back Problems	☐ Bells Palsy
☐ Biaxin	☐ Bleeding Extreme	☐ Blood Transfusions	☐ Cancer
☐ Cephalexin Allergy	☐ Chemo Port	☐ Chemotherapy	☐ Cipro Allergy
☐ Circulatory	☐ Clindamycin	☐ Codeine Allergy	☐ Codine
☐ Cold Sores	☐ Cortisone Treatments	☐ Cough Persistent	☐ Diabetes
☐ Dizziness	☐ Epilepsy	☐ Erythromycin Allergy	☐ Excessive Bleeding
☐ Extreme Anxiety	☐ Factor V leidoen blood clotting	☐ Fainting	☐ Glaucoma
☐ Hay Fever	☐ Head Injuries	☐ Headaches	☐ Heart Attack
☐ Heart Disease / Cond	☐ Heart Murmur	☐ Heart Stents	☐ Heart Valve Replaced
☐ Hemophilia	☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C
☐ High Blood Pressure	☐ High Cholesterol	☐ Ibuprofen	☐ Jaw Pain
☐ Kidney Disease	☐ Kidney stones	☐ Latex Allergy	☐ Latex Allergy
☐ Liver Disease	☐ Lupus	☐ METROPOLOL	☐ Mental Disorders
☐ Mitral ValveProlapse	☐ Nervous Disorders	☐ Nickel Allergy	☐ Other/Not on list *
☐ Pacemaker	☐ Parkinson's Disease	☐ Pennicillin Allergy	☐ Pre-Med
☐ Pregnancy	☐ Psychiatric Care	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Rheumatism	☐ Rubber Accelerator	☐ Scarlet Fever
☐ Seizures	☐ Shingles	☐ Shortness of Breath	☐ Sinus Problems
☐ Sjogrens	☐ Skin Rash	☐ Sleep	☐ Sleep Apnea
☐ Stomach Problems	☐ Stroke	☐ Sulfa Allergy	☐ Swollen Feet / Ankle
☐ Thyroid Problems	☐ Tobacco Use	☐ Tuberculosis	☐ Tumors
☐ Tylenol	☐ Ulcers	☐ VERTIGO	☐ Vicodin
☐ blood thinner	☐ cerebellarataxia	☐ copd	☐ osterperosis

If you checked Other/Not on list* please explain.

Have you had any serious illnesses or operations? * ○ Yes ○ No

If yes, please describe.

Have you taken or ever taken Bisphosphonates for Osteoporosis (i.e. Fosamax, Reclast, Zometa, Actonel)? *
○ Yes ○ No

If yes, please describe.

Have you ever had a blood transfusion? * ○ Yes ○ No

If yes, give approximate dates:

List of medications you are taking:

Allergies:

Getting To Know You

"Our promise is to provide you the opportunity for a dental experience that meets or exceeds your expectations in a caring, comfortable, and professional atmosphere. We will provide you preventive and restorative care to enhance your smile and overall health."

To help us serve your dental needs best, we would like to know more about you.
Please take a moment to complete the following questions:

What do you expect from your visit with us today?

What is most important to you about your dental health?

In your opinion, what is the present condition of your mouth?

What would you like your teeth to be like in 10 or 20 years?

Are you aware there are medical conditions related to dental disease? ○ Yes ○ No

What do you know about Periodontal Disease?

If you could "enhance" anything about your smile what would it be?

What foods do you enjoy, yet do not eat, due to discomfort with your teeth or any area of your mouth?

What has been your overall experience in other dental offices?

Has "fear" or "cost" ever prevented you from getting the dental treatment you needed or wanted? If Yes, please explain.

What "quality" of dentistry do you want us to focus on at this time?

○ "Patch it"

○ Only treatment covered by insurance

○ Ideal/Best

Should you be in need of treatment at what point do you plan to "get started"?

○ When it hurts

○ When it breaks

○ When it is recommended in order to prevent further deterioration

Please feel free to let us know more about how we can help make this your best dental experience.

Practice Guidelines

Our philosophy is to provide the highest quality of patient education and dental care to all patients that choose us for their dental care. Our hope is by providing you the following information we can prevent misunderstandings to ensure you encounter a positive experience. Please feel free to let us know if you have any questions or concerns.

EXPECTED PAYMENT
To keep our fees to you as low as possible, we ask that payment be made at the time of service. For your convenience an estimate for services will be prepared in advance of your appointment/s to ensure you opportunity to plan for your dental care. We believe whether you privately pay or have dental insurance to assist you, everyone deserves the care they need and want. It is necessary to provide accurate insurance information so estimates can be as accurate as possible.

DENTAL INSURANCE
We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. We request that you be familiar with your insurance benefits, and provide us the correct information to assist you with the submittal of claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received from them within 45 days. Please realize that your insurance is a contract between you and you, your employer, and the insurance company; therefore, we cannot guarantee coverage or eligibility and your assistance may be requested to expedite the processing of your claim. Not all services are covered benefits in all contracts; therefore you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is indicated regardless of your dental insurance benefits, deductibles, limitations, or maximums.

PAYMENT OPTIONS
For you convenience we provide a variety of payment options such as Cash/Check, MasterCard, Visa, and Discover, Should you desire a monthly payment plan we offer Care Credit and Prosper Health Care Lending. A simple application process is necessary and is subject to approved credit.

PAST DUE BALANCES
All balances must be resolved within 90 days to avoid outside collection proceedings. Payment of any past due balance is required to be paid in full before incurring new charges.

CANCELLATIONS
We consider all appointments confirmed when they are reserved. We do not double book with anticipation of patients not showing for their needed dental care. We require a 48 hour advance notice to change or cancel an appointment in order to allow enough time to offer the appointment to another patient in need. Improper notification may result in a $50.00 per hour fee.

INFORMATION CHANGES
To ensure your records are current please notify us of any changes related to medical history, telephone number/s, address, employer or insurance information as they occur.

WARRANTY
You, as my respected patient, and I are entering into a contract. I will warranty my work for 5 years for all major treatment as along as you do your part by following the prescribed maintenance, which includes, but not limited to, brushing, flossing, wearing a mouth guard and coming in for the needed continuing care appointments. Working together we can make the work we do remain beautiful and functional for years to come.

☐ *

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature _____ **Date** _____

Relationship to Patient:

_____

_____

_____

Response Date: _____