

Patient Information

Patient's Name _____ Birth Date _____ SS# _____

Sex _____ Marital Status _____ # of Children _____ E-mail _____

Home Address _____ City _____ St _____ Zip _____

Home Phone _____ Work Phone _____ ext. _____ Cell Phone _____

Employer _____ Occupation _____

Name of Spouse/Parent _____ Birth Date _____ SS# _____

Address(if different) _____ City _____ St _____ Zip _____

Phone #(if different) _____ Work Phone _____ Cell Phone _____

Responsible Party _____ Relationship _____ Phone _____

Whom may we thank for referring you to our office? _____

OUR FINANCIAL POLICY- Payment is expected at the time of service. We accept cash, checks, Visa, MC, and Discover. For treatment plans over \$500 we offer payment plans of 6 or 12 months. If you have questions regarding fees or need to set up a payment plan, it **must** be done prior to receiving treatment.

INSURANCE AGREEMENT- I understand that my dental insurance is a contract between my insurance company and myself, not between the insurance carrier and the dentist. Therefore, I am responsible for all dental fees. I understand that my dental insurance may pay less than the actual bill for service, or estimate given to me. I agree to be responsible for payment of all services rendered to me or my dependants. When we accept your insurance, you must pay your deductible plus your estimated insurance co-payment at the time of service. If your insurance company has not paid the full balance within 45 days, the balance becomes your responsibility. If there is a discrepancy between your co-payment and what your insurance company pays, the balance is due when you receive the statement from our office. If your insurance company pays more than the balance due, we will send a refund check or credit your account immediately. We file insurance claims as a courtesy to you. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary for claims processing. You are responsible for the timely payment of your account.

ATTENTION- If your account becomes 60 days delinquent, it will be turned over for collections. You will be responsible for the balance plus any fees associated with collection of the account.

I certify that I have read or had read to me and understand the contents of this form.

Signature _____ Date _____
(Parent or Guardian if minor)

If you have dental insurance present your card to our office staff. We will verify your coverage and review the benefits with you.

Name: _____

HEALTH HISTORY FORM

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information is confidential and for our records only.

Do you now or have you had any of the Following Cardiovascular Disease?

Check any that apply:

- Angina/Chest Pain
- Coronary Bypass
- Congestive Heart Failure
- High Blood Pressure
- High Cholesterol
- Pacemaker
- Rheumatic Fever
- Stents
- Heart Valve Replacement
- Heart Murmur
- Mitral Valve Prolapse
- Congenital Heart Defect

CHECK ANY THAT APPLY:

- Anemia
- Asthma
- Artificial Joint _____
- Arthritis
- Bleeding Problems
- Bronchitis/COPD/Lung Problems
- Cancer _____
- Depression
- Diabetes
- Drug/Alcohol Treatment
- Epilepsy/Seizures
- GERD/Acid Reflux
- Glaucoma
- HIV/AIDS
- Hepatitis A B C unknown
- Kidney Disease
- Liver Disease
- Organ Transplant _____
- Osteoporosis
- Radiation Treatment
- Seasonal Allergies
- Sinus Problems
- Sexually Transmitted Disease
- Skin Problems
- Stroke or TIA
- Thyroid Problems

Are you pregnant? _____

Do you have any disease, condition, or problem not listed that you feel we should know about?

Have you ever been told that you require antibiotics before a dental appointment? _____

If yes, for what condition? _____

Are you **ALLERGIC** to any medications, foods, or latex?(do you get hives, a rash, have trouble breathing, etc.)? _____

List any **MEDICATIONS** that you are currently taking:

Social History -

Do you smoke? _____ How long have you smoked? _____

How much do you smoke? _____

Do you use smokeless tobacco? _____

Do you drink alcohol? _____

How often do you drink? _____

Dental History-

When was your last dental cleaning? _____

How often do you brush? _____ floss? _____

Do you clench or grind? _____

Have you been told that you have TMJ problems? _____

Does your jaw pop or click? _____

Do your gums bleed? _____

Have you been told you have periodontal(gum) disease? _____

List any other dental problems or concerns that you have:

Are you interested in cosmetic work such as bleaching, veneers, replacing old silver fillings with tooth colored, braces, etc.? _____

Comments:

I have read or had this form read to me and have completed it as accurately as possible. I understand false or incomplete information on this form could jeopardize my health while receiving dental care.

Signature

Date