



## PATIENT INFORMATION

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

If Child, Parent's Name: \_\_\_\_\_

Patient/Parent Social Security: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_

Present Position: \_\_\_\_\_

Spouse Name: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_

Spouse Present Position: \_\_\_\_\_

Who is Responsible For This Account? \_\_\_\_\_

How Did You Hear About Us?

- |  |  |
|--|--|
| <input type="checkbox"/> Friend or Family      | <input type="checkbox"/> Online/Website  |
| <input type="checkbox"/> Professional Referral | <input type="checkbox"/> Google/Search   |
| <input type="checkbox"/> Sign/Drive By         | <input type="checkbox"/> Facebook        |
| <input type="checkbox"/> Insurance Provider    | <input type="checkbox"/> Community Event |
| <input type="checkbox"/> The News-Herald       | <input type="checkbox"/> Other: _____    |

### Primary Dental Insurance Provider

Employee Name: \_\_\_\_\_

Employee Date of Birth: \_\_\_\_\_

Employee Social Security: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Union Local or Group Number: \_\_\_\_\_

### Secondary Dental Insurance Provider

Employee Name: \_\_\_\_\_

Employee Date of Birth: \_\_\_\_\_

Employee Social Security: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

What's the best way to contact you?

- |                                |
|--------------------------------|
| <input type="checkbox"/> Phone |
| <input type="checkbox"/> Email |
| <input type="checkbox"/> Text  |

### Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement I agreed to be responsible for payment of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

**Patient or Guardian Signature:** \_\_\_\_\_

When was your last visit to the dentist? \_\_\_\_\_

Date of your last dental x-rays? \_\_\_\_\_

Primary dental concerns you are having? \_\_\_\_\_

Do you consider these concerns an emergency? \_\_\_\_\_

**TMD History**

Y	N	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent headaches?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain in or around the jaw joint? (Circle) Right or Left?
<input type="checkbox"/>	<input type="checkbox"/>	When is the pain worse? (Circle) Mornings / Evenings / At meals / No specific time
<input type="checkbox"/>	<input type="checkbox"/>	Do you have clicking, popping, or grating noise in your jaw joint? (Circle) Right or Left?
<input type="checkbox"/>	<input type="checkbox"/>	Has your mouth ever locked open so you were unable to close it?
<input type="checkbox"/>	<input type="checkbox"/>	Are you aware of clenching or grinding your teeth? When: _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking, or have you taken, medication for jaw discomfort?
<input type="checkbox"/>	<input type="checkbox"/>	Have you been treated for TMD therapy?

**PERIO History**

Y	N	Condition	Home Care	Times Per Day
<input type="checkbox"/>	<input type="checkbox"/>	Do your gums bleed when brushing or flossing?	Brushing:	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have red, swollen or tender gums?	Flossing:	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have receding gums?	Mouthwash:	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you previously been diagnosed with gum disease?		

**Smile Evaluation**

Y	N	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Would you like your teeth to be whiter?
<input type="checkbox"/>	<input type="checkbox"/>	Would you like your teeth to be straighter?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have spaces between your teeth that you would like closed?
<input type="checkbox"/>	<input type="checkbox"/>	Would you like your teeth to be longer?
<input type="checkbox"/>	<input type="checkbox"/>	Do you like the shape of your teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have missing teeth that you would like to replace?
<input type="checkbox"/>	<input type="checkbox"/>	Would you like to replace old silver fillings with tooth-colored fillings?

**Sleep Apnea History** (for patients previously diagnosed with sleep apnea)

Y	N	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a sleep study?
<input type="checkbox"/>	<input type="checkbox"/>	If yes, what facility performed the study? _____ What year? _____
<input type="checkbox"/>	<input type="checkbox"/>	May we request a copy of the study?
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently using CPAP or any other therapy for your sleep apnea?

Please answer the following:

<b>Y</b>	<b>N</b>	<b>Condition</b>
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke or use tobacco?

Females, please answer the following:

<b>Y</b>	<b>N</b>	<b>Condition</b>
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking birth control pills?

Y	N	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Bones/Valves
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Bisphosphonates
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily
<input type="checkbox"/>	<input type="checkbox"/>	Cancer- Chemotherapy
<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect
<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches

Y	N	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	HIV + AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems
<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Recent Surgeries
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Stroke

Y	N	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Do You Snore
<input type="checkbox"/>	<input type="checkbox"/>	Wake up Frequently
<input type="checkbox"/>	<input type="checkbox"/>	Daytime Sleepiness
<input type="checkbox"/>	<input type="checkbox"/>	Past Sleep Study
<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea

  

Y	N	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Sulfa
<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics

Current Medications (Please list any blood thinners):

Any disease, condition or other problems our office should know about that wasn't covered above?

Y  N Please describe below



## FINANCIAL POLICY

Payment for care is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, American Express, Discover or financing through Care Credit upon approval of a credit application.

If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this, we need your assistance in understanding our payment policy. **Your insurance is a contract between you, your employer and the insurance company.** WE ARE NOT A PARTY TO THAT CONTRACT. Not all services provided are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. Any claim that remains outstanding by the insurance company over 90 days immediately becomes your responsibility.

Returned checks and balances older than 30 days will be subject to additional collection fees.

If you have any questions about the above information or have any uncertainty regarding insurance coverage, please ask us. We are here to help.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY

Name \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_