GREAT LAKES DENTAL

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? _____

Emergency Contact: _____

Emergency Phone: _____

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: _____

How Did You Hear About Us?

- ☐ Friend or Family
- ☐ Professional Referral
- ☐ Sign/Drive By
- ☐ Insurance Provider
- ☐ The News-Herald
- ☐ Online/Website
- ☐ Google/Search
- ☐ Facebook
- ☐ Community Event
- ☐ Other: _____

What's the best way to contact you?

- ☐ Phone
- ☐ Email
- ☐ 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: _____

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PATIENT DENTAL HISTORY

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

PERIO History

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

Smile Evaluation

Y	N	Condition
☐	☐	Would you like your teeth to be whiter?
☐	☐	Would you like your teeth to be straighter?
☐	☐	Do you have spaces between your teeth that you would like closed?
☐	☐	Would you like your teeth to be longer?
☐	☐	Do you like the shape of your teeth?
☐	☐	Do you have missing teeth that you would like to replace?
☐	☐	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
☐	☐	Have you ever had a sleep study?
☐	☐	If yes, what facility performed the study? _____ What year? _____
☐	☐	May we request a copy of the study?
☐	☐	Are you currently using CPAP or any other therapy for your sleep apnea?

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PATIENT MEDICAL HISTORY

Please answer the following:

Y	N	Condition
☐	☐	Abnormal Bleeding
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones/Valves
☐	☐	Asthma
☐	☐	Bisphosphonates
☐	☐	Blood Transfusion
☐	☐	Bruise Easily
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	HIV + AIDS

Y	N	Condition
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Pace Maker
☐	☐	Mitral Valve Prolapse
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Recent Surgeries
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Smoking/Vaping
☐	☐	Stroke
☐	☐	Tuberculosis
☐	☐	Thyroid Problems
☐	☐	Ulcer

Y	N	Allergies
☐	☐	Codeine
☐	☐	Erythromycin
☐	☐	Penicillin
☐	☐	Tetracycline

Y	N	Females
☐	☐	Are You Pregnant?
☐	☐	Are You Nursing?
☐	☐	Taking Birth Control?

Y	N	Sleep Conditions
☐	☐	Do You Snore?
☐	☐	Wake Up Frequently?
☐	☐	Daytime Sleepiness?
☐	☐	Past Sleep Study?
☐	☐	Sleep Apnea

Y	N	Children Under 12
☐	☐	Snoring
☐	☐	Teeth Grinding
☐	☐	Sleeps with Mouth Open
☐	☐	Bedwetting

Other Allergies:

Current Medications and Supplements:

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

☐ Y ☐ N Please describe below

GREAT LAKES
DENTAL

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 _____ / _____ / _____