WELCOME TO OUR OFFICE!

We are pleased you have selected us to provide dental care for you and your family. Our first responsibility is to provide the utmost in dental care at the lowest possible cost to you. One way we are able to keep our fees as low as possible is to reduce our billing and bookkeeping costs. So then, payment is expected at the time of treatment. Any co-pay amount not paid at the time of treatment will result in a $5 fee each month that a statement must be sent to you until the balance is paid in full. It is important to give us as much notice as possible for rescheduling or canceling an appointment. There will be a minimal charge for broken appointments.

Date __________________ **Whom may we thank for referring you?** __________________

What do you prefer to be called? __________________

PATIENT INFORMATION

Name__________________
Last **First** **Middle Initial**

Address__________________
Street **City** **State** **Zip** **Phone #**

Sex M F Date of Birth_____/______/_____ **Marital Status: Single Married Divorced Widowed Separated**

Social Security #__________________

Spouse's Name________________________ **How many children do you have?** ________ **Their names?** ______________________

Patient Employed? Yes No

Employment Info__________________
Name **Address** **City, State, Zip** **Phone #**

Is Patient Full-time Student? Yes No

School__________________
Name **City** **State**

Your Hobbies? __________________

RESPONSIBLE PARTY INFORMATION (if different than patient)

Name__________________
Last **First** **Middle Initial**

Address__________________
Street **City** **State** **Zip** **Phone #**

Sex M F Date of Birth_____/______/_____ **Marital Status** ____________ **Social Security#**__________________

Employment Info__________________
Name **Address** **City, State, Zip** **Phone #**

Occupation__________________ **Years at position**__________________

DENTAL INSURANCE INFORMATION

Note: Filing of insurance claims to primary insurance carriers is done as a courtesy to our patients. If you have secondary insurance, we will be happy to provide you an itemized list of services so that you may submit to your secondary insurance provider for direct reimbursement.

Insurance Co.__________________**Phone**__________________

Address__________________
City **State** **Zip**

Group Name__________________ **Group #**__________________

Effective Date__________________ **Relation to Patient**__________________

MEDICAL HISTORY

Do you have any known health problems? **YES** **NO**
Are you currently under a physician's care? **YES** **NO**
What for?____Physician's Name_________________________________
Have you been hospitalized in the last two years? **YES** **NO**
What for?____
Are you now taking any medication or drugs? **YES** **NO** Please List_____________________________________
Are you allergic to any medication or anesthetics? **YES** **NO**
If yes, please list:____
Are you Pregnant? **YES** **NO** What month?______________________________________
Do you smoke? **YES** **NO** What?_____________How Long?__________________
Do you chew Tobacco? **YES** **NO** How Long?_______________________________________

Do you have or have you had any of the following conditions?

___Heart Disease/Attacks
___Rheumatic Fever
___Mitral Valve Prolapse
___Artificial Joints
___Congenital Heart Disease
___High/Low Blood Pressure
___Thyroid Problems
___Glaucoma
___Blood Diseases
___Diabetes
___Drug Addiction
___Asthma
___Allergy to Metals
___Allergy to Latex
___Cortisone Medicine
___Emphysema
___Ulcers
___Arthritis
___Tuberculosis
___Kidney Disorder
___Venereal Disease
___Liver Disease
___Stroke
___Seizures
___Heart Murmur
___Cancer
___Pacemaker
___Sinus Trouble
___HIV or AIDS

Please list anything disease, condition or problem not listed above____

DENTAL HISTORY

Do your gums bleed when you brush? **YES** **NO**
Do you grind/clench your teeth **YES** **NO**
Do you have fear of dental work? **YES** **NO**
Are your teeth sensitive to hot/cold? **YES** **NO**
Have you had orthodontic work? **YES** **NO**
Date of last dental X-rays__________________________________
What prompted you to seek dental care at this time?____
How do you feel about the appearance of your teeth?____
How long has it been since your last professional dental cleaning?____
Who was your former dentist?__________________________________City__________________State__________________

Consent:

1. The undersigned hereby authorizes the doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with the patient. I understand that using anesthetic agents embodies certain risk. Furthermore, I authorize and consent that doctor chooses and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time of service, unless other financial arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 ½ % finance charge (18% APR) may be added to my account in addition to any collection charges, and agree to pay reasonable attorney's fees. I further understand that any amount my insurance does not pay is my responsibility, as this office is not in control of third party payments. Additionally, I acknowledge that insurance coverage is not guaranteed and co-pay amounts are estimated, based on the benefits researched and outlined in my policy.
4. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
5. I authorize the use of my social security number to file my dental claim.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Responsible Party____**Date**_____________