New Patient Information

Patient Name____ Preferred Name___________________________

Address____
Street City State Zip

Home Phone____________________ Cell Phone________________________ Work Phone__________________

Sex:____ Birth date_______________ SS#__________________________ Marital Status___________________

Email:____ Preferred Pharmacy:______________________________

RESPONSIBLE PARTY INFORMATION

Name__________________________ Birth date _________SS#________________ Marital Status__________

Address____
Street City State Zip

Home Phone_____________________ Cell Phone____________________ Work Phone__________________

Employer________________________ Employer Phone_________________ Occupation_________________

INSURANCE INFORMATION

Insurance Name___________________________ Subscriber Name________________ ID#_________________

Subscriber Birth Date_____________ Group#___________________ Relationship to patient__________________

Do you have dual coverage? Yes No If Yes:

Insurance Name___________________________ Subscriber Name________________ ID#_________________

Subscriber Birth Date______________ Group#___________________ Relationship to patient_________________

I, the undersigned certify that I (or my dependent) have insurance coverage with the insurance listed above. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize my insurance to pay my benefits directly to the dentist for all services rendered. I authorize the use of this signature for all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

Responsible Party Signature____

Relationship____Date ________________________

Whom may we thank for referring you? ____

Is another member of your family a patient at our practice? YES or NO

Name____

EMERGENCY INFORMATION

In case of emergency please contact _______________________________________Phone__________________

Dental Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the cost incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:
All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time of service are rendered. All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies and will credit any collections from insurance to the patient's account. Fee estimates for dental care only be extended for a period of six months from the date of consultation. Payment for services is due at the time of treatment.

☐ **By checking this box, I acknowledge that I have read, and fully understand and agree to the terms of this Financial Policy.**

Notice of Privacy Practices Acknowledgement

The privacy of your health information is important to us. Our Notice of Privacy Practices describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge that you received a copy and/or reviewed our Notice of Privacy Practices.

☐ **By checking this box, I acknowledge that I have received a copy or got to review our dental practice's Notice of Privacy Practices.**

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

Signature ____ Date___________

Name and relationship to patient____

Medical History

Indicate which of the following you have had or have at present. By checking the box, it will indicate a “Yes” response, leaving blank will indicate a “No” response.

☐ Pre-Med (Amox)	☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Cancer	☐ Diabetes	☐ Dizziness	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma	☐ Head Injuries	☐ Drug Dependency
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis	☐ Herpes	☐ High Blood Pressure
☐ HIV Positive	☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders
☐ Nervous Disorders	☐ Pacemaker	☐ Pregnancy	☐ Breast feeding	☐ Stroke
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism	☐ Sinus Problems	☐ Stomach Problems
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Deaf	☐ Venereal Disease
☐ Alcoholism	☐ Eating Disorder	☐ Gag Easily	☐ Heart Attack	☐ Smoker/Tobacco
☐ Hives	☐ Hyper Activity	☐ Chemotherapy	☐ AIDS	☐ Blood Thinners
☐ Emphysema	☐ Radiation Treatment	☐ Angina	☐ Headaches	☐ Birth Control

Are you **ALLERGIC** to or have you had a bad reaction to:

☐ Aspirin	☐ Barbiturates	☐ Codeine	☐ Erythromycin	☐ Iodine
☐ Keflex	☐ Local Anesthetic	☐ Nitrous Oxide	☐ Narcotics	☐ Penicillin
☐ Sulfa	☐ Tetracycline	☐ Latex	☐ Other ___________	

Please list any medication you are taking now____

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Physician name _____________________ Office Phone # __________________Most recent physical exam___________________

Date of most recent dental exam_____________________ Date of most recent dental x-rays_______________________________

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _______________________________________

Check all that apply to your dental history:

☐ Had an unfavorable dental experience	☐ Had trouble getting numb	☐ Has any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment	☐ Had teeth removed	☐ Have problems with your jaw joint
☐ Chewing problems	☐ You clench your teeth in the daytime	☐ Wake up in the morning to a sore jaw
☐ Gums bleed when brushing or flossing	☐ Noticed an unpleasant taste or odor in your mouth	☐ Treated for gum disease
☐ History of periodontal disease	☐ Experienced gum recession	☐ Had any teeth become loose on their own
☐ Food gets caught between your teeth	☐ You wear or have worn a bite appliance/nightguard	☐ Have you ever been on bisphosphonates or other bone density medications
☐ Chipped or broken teeth	☐ Whitened your teeth in the past	☐ Have felt uncomfortable or self-conscious about your appearance of your teeth

CONSENT: As the undersigned, I hereby authorize Doctor to, after thorough explanation, take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated (after discussed with me) and further authorize and consent that Doctor choose and employ such assistance as they deem necessary. I also understand the use of anesthetic agents embodies a certain risk.

Signature of Patient ___________________________________Print Name_____________________________

Relationship to Patient____Date______________________