Thank you for choosing our office. We are committed to providing you with the highest quality dental care so you may achieve optimum lifetime oral health. Please read and complete the information below to serve you better.

Tell Us about You	
Patient's Name:	
Sex:	☐ Male ☐Female
Date of Birth:	____/____/____ Age: _____
Today's Date:	
Home Phone:	
Home Address:	
City, State, Zipcode:	
Status:	☐ Single ☐ Married ☐ Separated ☐ Widowed
Your Employer:	
How Long Employed:	
Social Security #:	
Work Phone:	
Are you a full time student?	☐Yes ☐No
If Patient is a Minor:	Mother's Birth Date: ____/____/____ Father's Birth Date: ____/____/____
Person Responsible for Account:	
Driver's License #:	
Name of Spouse (Parent if Minor):	
Email Address:	
Cell Phone:	
Spouse's (Parent's) Employer:	
Spouse's Soc. Sec. #:	
Work Phone:	
Emergency Info:	Name, Address & Telephone # of a Relative Not Living with You.
How did you hear about our office?	

DENTAL INSURANCE INFORMATION (Primary Carrier)			
Primary Carrier		**Secondary Insurance**	
Insured's Name:		**Insured's Name:**	
Date of Birth:		**Date of Birth:**	
Social Security #:		**Social Security #:**	
Insured's Employer:		**Insured's Employer:**	
Insurance Company:		**Insurance Company:**	
Insurance Co. Address:		**Insurance Co. Address:**	
Insurance Phone #:		**Insurance Phone #:**	
Insurance Group #:		**Insurance Group #:**	
Insurance ID#:		**Insurance ID#:**	

OUR FINANCIAL INFORMATION

- Please understand that payment of your bill is considered part of your treatment.
- Payment is due at the time service is provided. Our office accepts **cash, personal checks, MasterCard, Visa, and Discover**. Outside financing is available upon request and approval.
- **Please check if you would like more information about financing options.** ☐
- **Please Note:** Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal services, you will be responsible for any collection and/or legal charges incurred up to 35%.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim. We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Consent: The undersigned hereby authorizes Doctor to take 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. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

PATIENT SIGNATURE (Parent of Child):_____DATE:_____

TELL US ABOUT YOUR TEETH & DENTISTRY

Are you experiencing or ever experienced any of the following:

- Tooth Sensitivity (hot, cold, sweet) ☐
- Where: UR LR UL LL ☐
- Headaches, earaches, neck pain ☐
- Jaw joint pain ☐
- Teeth or fillings breaking ☐
- Grinding or clenching teeth ☐
- Bleeding, swollen or irritated gums ☐
- Loose, tipped or shifting teeth ☐
- Bad Breath ☐

If you could change your smile, would you…?

- Make them whiter? ☐
- Make them straighter? ☐
- Close Spaces? ☐
- Repair chipped teeth? ☐
- Replace missing teeth? ☐
- Replace old crowns that don't match? ☐
- Replace black metal fillings? ☐
- Have a smile makeover? ☐

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

- Dentures ☐
- Partial Dentures ☐
- Braces ☐
- Periodontal (Gum) Treatment ☐

Date of Last Cleaning:

Date of Last Oral Cancer Screening:

Date of Your Last Complete X-Rays:

Name of Last Dentist:

Phone & Address of Last Dentist:

Why did you leave your previous dentist?

Did you smoke or use chewing tobacco?

How much: How long:

On a scale from 1 -10 (10 being the highest):

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

How do you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

If you could whiten your teeth for a cost anyone could afford, would you do it?

What is the most important thing to you about your dental visit today?

What is the most important thing to you about your future smile and dental health?

MEDICAL HISTORY

Patient Name:

Please check the boxes of the following problems or conditions that you have or have had in the past:

☐ Anemia	☐ Stroke	☐ Jaw Joint Pain	☐ Stomach Problems
☐ Bruise/Bleed Easily	☐ Rheumatic Fever	☐ Kidney Disease	☐ Ulcers
☐ Blood Disease	☐ Mitral Valve Prolapse	☐ Liver Disease	☐ Diabetes
☐ AIDS or HIV	☐ Pacemaker	☐ Jaundice	☐ Pregnant or Nursing
☐ Hepatitis A	☐ Artificial Heart Valve	☐ Lupus/other Autoimmune	☐ Thyroid Disease
☐ Hepatitis B	☐ Scarlet Fever	☐ Multiple Sclerosis	☐ Phen Fen (1 Month+)
☐ Hepatitis C	☐ Bone Density	☐ Seizures	☐ Venereal Diseases
☐ High Blood Pressure	☐ Osteoporosis	☐ Nervousness/Depression	☐ Glaucoma
☐ Low Blood Pressure	☐ Arthritis	☐ Asthma	☐ Drug Addiction
☐ Dizziness/Fainting	☐ Artificial Joints	☐ Tuberculosis	☐ Other:
☐ Heart Conditions	☐ Rheumatism	☐ Allergies (Seasonal)	☐ Other:
☐ Heart Attack	☐ Cancer	☐ Respiratory Problems	☐ Other:
☐ Heart Murmur	☐ Chemotherapy	☐ Emphysema	☐ Other:
☐ Heart Surgery	☐ Radiation(Head/Neck)	☐ Tobacco Habit	☐ Other:

PLEASE LIST ALL ALLERGIES:(ANY DRUGS, MEDICATIONS,LATEX,FOODS, METALS, JEWELRY,PLASTICS, ACRYLICS)

_____

_____

_____

_____

Are you under a physician's care? ☐ **Yes** ☐ **No**

What for:

Family Physician: **Phone:**

Have you been hospitalized or had any in-patient or out-patient surgeries in the past five years?

o No o Yes, explain _____

LIST ALL MEDICATIONS, PILLS, VITAMINS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Are you taking any birth control? o Yes o No

Patient Signature (or Parent/Guardian): **Date:**

Doctor Signature: **Date:**

FOR OFFICIAL USE ONLY: UPDATES

Updated Contact Information: Phone: _____ Cell Phone: _____ Email: _____

Updated Address: _____

Update:	Changes:	Initial:
Update:	Changes:	Initial:
Update:	Changes:	Initial:

NOTICE OF PRIVACY NOTICE – WRITTEN PERMISSION

There's been a development in the health industry that requires us to get your written permission in case we ever need to share your treatment information with a specialist, dental lab, or an insurance company. When you sign this form, you give us your approval to share your treatment information and you acknowledge that you are aware of our potential need to do so.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices. I also give my permission should it be necessary to share my treatment information. A copy of this notice and acknowledgement will be kept in my Patient file.

You may refuse to sign this acknowledgement. However, without your signature, we cannot file your insurance or treat you today.

Please Print your Name:

Patient Signature:
Date:

For Office Use Only (Patients should not write below this line):

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify):