



*Please take your time to fill out these forms completely. The more we learn about you the better care we can provide.*

**Patient Information**

Today's Date: \_\_\_\_\_

Legal First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

I prefer to be called (Nickname, etc.): \_\_\_\_\_  Male  Female  Other: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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

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

Contact Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Home  Cell  Work  Other: \_\_\_\_\_

Alternate contact number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Home  Cell  Work  Other: \_\_\_\_\_

Email: \_\_\_\_\_

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

Spouse's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency contact name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Whom may we thank for referring you:**  Company Webpage  Facebook  Instagram  Army  Air Force

Family/Friend: \_\_\_\_\_  Other: \_\_\_\_\_

**Dental History**

Reason for today's visit: \_\_\_\_\_

Are you currently in Pain?  Yes  No

If so, please describe: \_\_\_\_\_

Do you have any dental problems now?  Yes  No

If so, please describe: \_\_\_\_\_

Have you ever had trouble with previous dental treatment that you would like us to know about?  Yes  No

If so, please describe: \_\_\_\_\_

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

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*(If you don't know the dates of the following, take your best guess: 6 months, 1 year, 5 years, 20 years, never)*

Date of last dental exam: \_\_\_\_\_ Date of last cleaning: \_\_\_\_\_ Date of last x-rays: \_\_\_\_\_

Procedure(s) done at last dental appointment: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Previous Dentist Phone number: (\_\_\_\_\_) \_\_\_\_\_

Why are you changing dentists: \_\_\_\_\_

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How often do you have dental examinations? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

How often do you have dental cleanings? \_\_\_\_\_ How often do you brush your teeth? \_\_\_\_\_

What type of bristles do you use:  Hard  Medium  soft

What other dental aides do you use? (Electric toothbrush, water flosser, etc.): \_\_\_\_\_

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Do you require antibiotics before dental treatment?  Yes  No    Do you bite your lips or cheeks frequently?  Yes  No

Are you on any blood thinners?  Yes  No    Do you have frequent headaches?  Yes  No

Do your gums ever bleed?  Yes  No    Do you clench or grind your teeth?  Yes  No

Have you noticed any mouth odors or bad taste?  Yes  No    Do you still have your wisdom teeth?  Yes  No



**Do you currently have any of the following:**

- Loose teeth
- Broken teeth
- Lost or broken fillings
- Lost or broken crowns/bridges
- Sensitivity when biting
- Sensitivity to hot
- Sensitivity to cold
- Sensitivity to sweets/sugar
- Food collection between teeth
- Sores in your mouth

**Have you ever had:**

- Periodontal disease/gum treatment:  Yes  No
- Orthodontic treatment (braces, etc.):  Yes  No
- Oral surgery (wisdom teeth extraction, etc.):  Yes  No
- A bite plate or night guard:  Yes  No
- Discomfort/popping in your jaw joint (TMJ/TMD):  Yes  No
- Your teeth ground or bite adjusted?:  Yes  No
- Serious injury to the mouth or head:  Yes  No

If you said yes to any of the previous questions, please describe:

\_\_\_\_\_

Is there anything else about your dental past you would like us to know?

\_\_\_\_\_

**Treatment Consent**

I consent to treatment which is advisable and agreeable to both myself and the dentist knowing that certain rare complications may occur. These may include:

- Injury to adjacent restorations, teeth or other tissues
- Trismus: a prolonged stiffness of muscle(s)
- Fistula: small openings between the mouth and sinus following the removal of upper teeth
- Bone fractures
- Paresthesia: a nerve involvement that may result in numbness of the chin, tongue, teeth, lips, or gums
- Dry socket

I understand that there isn't a guaranteed outcome for any treatment. I realize that additional procedures may become an apparent need during treatment and allow the dentist to utilize his/her best judgment.

Patient name: \_\_\_\_\_ Legal Guardian: \_\_\_\_\_

Patient or legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Permission to release private health information**

Please do not share dental information

I hereby give permission for the following people to have access to my private health information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I give permission for the above listed people to have access to my records including but not limited to records, diagnosis, recommended treatment, dates of any past or present treatment, and all financial records associated with past or present treatment. I acknowledge that this permission is optional and can be revoked at any time in writing by me. I understand that this permission is in addition to the office's existing permissions as explained in the office's privacy practices and shall remain in effect until revoked.

Patient name: \_\_\_\_\_ Legal Guardian: \_\_\_\_\_

Patient or legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Medical History**

Within the last 2 years have you had any hospitalizations, illnesses, or operations?  Yes  No

If yes, please describe: \_\_\_\_\_

Hospital or Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Are you currently taking any medications? (Include regular doses of aspirin or over-the-counter medications):  Yes  No

If yes, please List: \_\_\_\_\_

(Use the back of this page if you need more room, or if you have a current list ask the front desk to take a copy)

**WOMEN:** Are you currently taking birth control:  Yes  No

Are you pregnant?  Yes  No  Maybe Due Date: \_\_\_\_\_ Are you nursing?  Yes  No

**MEN/WOMEN: Please check any of the following issues:**

- Acid Reflux/GERD
- AIDS/HIV
- Alcohol/Drug Abuse
- Allergies or Hives
- Anemia
- Arthritis/Rheumatism
- Artificial Heart Valve
- Artificial Bones/Joints
- Asthma
- Blood Disease
- Blood Transfusion
- Bruise Easily
- Cancer/Chemotherapy
- Chest Pain
- Circulatory Problems
- Cold Sores/Herpes
- Colitis
- Contact Lenses
- Cortisone Medicine
- Cough, persistent
- Diabetes
- Diet (Special/Restricted)
- Difficulty Breathing
- Emphysema
- Epilepsy or Seizures
- Fainting or Dizzy Spells
- Frequent Headaches
- Glaucoma
- Hay Fever
- Heart Attack, year: \_\_\_\_\_
- Heart Disease
- Heart Surgery, year: \_\_\_\_\_
- Heart Pacemaker
- Heart Murmur
- Hemophilia/Abnormal Bleeding
- Hepatitis A B C (circle)
- High Blood Pressure
- High Cholesterol
- Hospitalized for Any Reason
- Jaundice
- Kidney Disease/Trouble
- Liver Disease/Trouble
- Low Blood Pressure
- Lupus
- Malignant Hyperthermia
- Mitral Valve Prolapse
- Nervousness/Anxiety
- Neurological Disorders
- Psychiatric/Psychological Care
- Radiation Therapy
- Respiratory Disease/Trouble
- Rheumatic/Scarlet Fever
- Shingles/Chicken Pox
- Sickle Cell Disease/Traits
- Sinus Trouble
- Smoking Habit (Tobacco, marijuana, etc.)
- Snoring/Sleep Apnea
- Stomach Problems/ Ulcers
- Stroke
- Swollen Ankles
- Thyroid Problems
- Tonsillitis
- Tuberculosis (TB)
- Tumors
- Other: \_\_\_\_\_

**Are you aware of having any allergic or adverse reactions to any of the following medications:**

- |                             |  |                                 |  |                                       |  |
|-----------------------------|--|---------------------------------|--|---------------------------------------|--|
| Aspirin                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Iodine                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sedatives                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Codeine                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jewelry/Metals                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sulfa Drugs                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anesthetics (i.e. Novocain) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tetracycline                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Erythromycin                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin or other antibiotics | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> other: _____ |  |

If yes, please describe: \_\_\_\_\_

Please list any medical conditions that you have had that are not listed above: \_\_\_\_\_

Patient name: \_\_\_\_\_ Legal Guardian: \_\_\_\_\_

Patient or legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Insurance Information**

No Insurance

By checking this box, I acknowledge that I have no insurance and that all costs are to be paid by me in full at the time of service.

***Primary Insurance***

Subscriber's Name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

relationship to patient: \_\_\_\_\_

Subscriber Social security number and/or Insurance ID number: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Insurance Group Name: \_\_\_\_\_ Insurance Group #: \_\_\_\_\_

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

Insurance mailing address: \_\_\_\_\_

Insurance City: \_\_\_\_\_ Insurance State: \_\_\_\_\_ Insurance zip code: \_\_\_\_\_

Insurance Phone number: (\_\_\_\_\_) \_\_\_\_\_ Electronic payer number: \_\_\_\_\_

***Secondary Insurance***

Subscriber's Name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

relationship to patient: \_\_\_\_\_

Subscriber Social security number and/or Insurance ID number: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Insurance Group Name: \_\_\_\_\_ Insurance Group #: \_\_\_\_\_

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

Insurance mailing address: \_\_\_\_\_

Insurance City: \_\_\_\_\_ Insurance State: \_\_\_\_\_ Insurance zip code: \_\_\_\_\_

Insurance Phone number: (\_\_\_\_\_) \_\_\_\_\_ Electronic payer number: \_\_\_\_\_

Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company might pay, it is the insurance company that makes the final determination of payment on your behalf. Any portion of the charges not covered by the insurance is ultimately your responsibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. This means it is your responsibility to know any and all limitations associated with your insurance policy. Failure to obtain a referral and/or preauthorization may result in a lower payment or no payment from your insurance company.

Patient name: \_\_\_\_\_ Legal Guardian: \_\_\_\_\_

Patient or legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Privacy Practices Acknowledgement and Receipt**

I, \_\_\_\_\_, have reviewed a copy of the office’s privacy practice and have asked any questions I may have. *\*You may refuse to sign this acknowledgment\**

Patient name: \_\_\_\_\_ Legal Guardian: \_\_\_\_\_

Patient or legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

For office use only:

We attempted to obtain written acknowledgment of receipt of our Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- other: Please specify: \_\_\_\_\_

**Office Policies**

Welcome to our office and thank you for choosing our office to serve your dental needs! We are dedicated to providing the highest quality dental care and services to our patients. We ask that you take a couple minutes to thoroughly read over our office policies. If you have any questions, please do not hesitate to ask.

**Appointments:**

We see patients on an appointment basis and strive to serve walk-in patients when time allows.

We consider an appointment to be a commitment between our office and our patient. We are counting on you to be here, on time for your scheduled appointment. If an appointment is canceled or missed without a 24-hour notice we may apply a charge of \$50.00 to your account. If this fee is applied, all previously scheduled appointment will be canceled until the fee is paid in full. Once you have paid this fee you will have the option to reschedule any canceled appointments.

For a new patient who no-shows, we will be unable to re-appoint you. If multiple appointments are missed, we may have no choice but to dismiss you from our practice.

If there are any extenuating circumstances that prevented you from attending, please call us as soon as possible. We are happy to review the situation and reverse any charges if necessary.

**Regular visits:**

Regular care is very important in preventing cavities and maintaining long-lasting dental health. We encourage our patients to return for their recommended visits and will inform you when you are due for your next visit at the end of each appointment. We may contact you via mail, email, text and/or telephone to ensure you are aware that you are due for your regular preventive care.

**Emergencies:**

If you have an emergency, please call the office right away and we will do everything possible to get you in at the earliest opportunity. If we are out of the office or it is after hours, we have an answering machine with instructions on how to reach one of our providers.

Please understand we try to keep your waiting time to a minimum and we know your time is valuable. Sometimes there are circumstances out of our control that dictate a waiting time longer than usual. When this happens, we try to give our patients a courtesy call to let them know there may be an additional waiting time. Please make sure we have current contact information for you on file so that we may contact you when needed.

I have read and understand the office policies listed above and I have had the opportunity to ask any questions. I agree to comply with the policies above.

Patient name: \_\_\_\_\_ Legal Guardian: \_\_\_\_\_

Patient or legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Financial Policies

When you are in the middle of treatment for a dental problem, it is easy to forget that a dental office is also a business. We understand that. We also want you to understand that an important part of any business is collecting payment for the services that are provided. We have created this financial policy to help alleviate any miscommunications regarding our billing practices. Please let us know immediately if you have any questions.

This is an agreement between our office as creditor/practice, and the patient/debtor named on this form. In this agreement the words "you", "your", and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us", and "our" refer to our office.

### ***Types of insurance:***

**Contracted:** We are participating providers with several insurance companies. Every policy is different and even though we are participating providers there are some policies that limit the reimbursement paid to us. It is your responsibility to be familiar with your insurance coverage and to determine whether or not we are the appropriate type of participating provider for your policy.

**Non-Contracted:** Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company might pay, it is the insurance company that makes the final determination of payment on your behalf. Any portion of the charges not covered by the insurance is ultimately your responsibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. This means it is your responsibility to know any and all limitations associated with your insurance policy. Failure to obtain a referral and/or preauthorization may result in a lower payment or no payment from your insurance company.

### ***Statements:***

If you have a balance on your account, we will send you a statement. These statements go first to the email on file, if that email is not opened within 7 days or there is no email on file they will go out in the mail. Please make sure your contact information is up to date with our office. The amount shown as your balance is due immediately.

### ***Payment options:***

Estimated amounts not covered by insurance are due the date services are rendered. There are NO exceptions unless pre-arrangements have been made **and** there is a signed treatment plan on file. Any insurance claim remaining unpaid by 90 days from the date of service is patient responsibility and will be due immediately.

If you have insurance:

1. You pay your deductible and any estimated co-pay on the day of service. This can be paid in cash or credit card.
2. You choose to pay your treatment in full by cash or credit card and have your insurance company send payments on your behalf to you.

If you don't have insurance:

1. You pay by cash or credit card on the day treatment is rendered
2. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.
3. We accept CareCredit with options starting at 6 months no interest if paid in full, on approval with CareCredit. CareCredit is a third-party lender and is not an in-house finance company.

### ***Fees and Past Due Accounts:***

A late fee of ten dollars (\$10) per month may be applied to accounts that are not paid within twenty-five (25) days of the statement.

A finance charge will be imposed on each item of your account that has not been paid within ninety (90) days of the time the item was added to the account. The finance charge will be computed at a monthly percentage rate of one percent (1%) per month, or at an annual percentage rate of twelve percent (12%) per year. You also agree to pay all attorney fees and cost of collection incurred if your account is not paid as agreed.

A missed appointment fee of fifty (\$50) for any appointment when an appointment is either abandoned (no-call, no-show) or canceled within 24 hours of the appointment date without a valid reason. This fee is not covered by any insurance. Any appointments scheduled after the fee is applied to your account will be canceled until paid in full.

**\*\*Patients missing an excessive number of appointments will be dismissed from our practice\*\***



**Credit Balances and refunds**

Occasionally an insurance company will pay more than we estimate on your behalf. If this occurs, we will issue you a refund check to the address on file (Please make sure you keep your contact information up to date). If you have a balance of less than ten dollars (\$10) this will remain on your account for future treatment unless a refund is requested by you.

**Workers Compensation/Personal Injury**

We require full payment up front unless other arrangements have been made. If a third-party is supposed to cover your treatment, they can reimburse you directly. We will be happy to provide detailed invoices in these cases.

**Credit History/Waiver of Confidentiality**

You give us permission to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau. You understand that is this account it submitted to an attorney or collection agency, if we litigate in court, or if your past-due status is reported to a credit reporting agency, any treatment at our office becomes a matter of public record.

**Divorce**

In case of divorce or separation, the party responsible for the account initially remains responsible for the account afterwards. The parent authorizing treatment for a child will remain responsible for any subsequent charges. If the divorce decree requires the other parent to pay for part or all of the treatment cost, it is the authorizing parent’s responsibility to collect from the other parent.

**Transferring records**

You must sign a written request if you want copies of your records and/or x-rays sent to another office. By doing this, you authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization, you authorize us to receive such information.

**Co-Signature**

If this or another financial policy is signed, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Patient name: \_\_\_\_\_ Legal Guardian: \_\_\_\_\_

Patient or legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient consent for electronic communication**

Preferred contact method

Email

Text

Phone call

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

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Consent to email, please initial the following:

\_\_\_\_\_ I am responsible for updating my email address with the office staff

\_\_\_\_\_ I am able to receive information electronically and store it securely away from any publicly accessible computers.

\_\_\_\_\_ I can withdraw my consent at any time for electronic communication by calling the office staff

Patient name: \_\_\_\_\_ Legal Guardian: \_\_\_\_\_

Patient or legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Last updated 02/18/2025