Welcome

About You. . .

Today's Date: ______________________________

Patient Name:____
LAST FIRST MI

What you prefer to be called:______________________________________ ❑ Male ❑ Female

Birthdate: _________________________ Age: ______ SS#: ______________________________

Mailing Address:____

____
CITY STATE ZIP

Home Phone: ________________ Cell Phone:________________ Work Phone: ________________

E-mail address for appointment reminders:____

Referred By:____

Employer: ____

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Person ultimately responsible for this account? Name _____________________________________

Relationship ________________________ Phone Number ______________________________

Emergency Contact Name________________________________ Phone ____________________

Do you have dental insurance? ❑ Yes ❑ No Employer_______________________________________

Subscriber____________________ DOB ____/_____/______ Insurance Company _________________

Policy _______________________ ID#________________ SS# ________________________

Dental Information:

Previous Dentist:____ (________)________________
NAME PHONE NUMBER

Last Dental Exam:_________/__________/_________ Last Dental X-rays:_________/__________/_________

Please Rate Your Dental Health (1-10) _______

Please Rate Your Smile (1-10) _______

- OVER -

Medical History:

What medications are you taking? Please list:____

____

Pharmacy____

Do you require pre-medication (antibiotics) before dental appointment? ❑ Yes ❑ No ❑ Don't Know

If yes, please explain: ____

Doctor who did the surgery: ____________________ Antibiotics prescribed: ____________________

Do you take blood thinners? ❑ Yes ❑ No If yes, please list: ____________________

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack	**Y N** Emphysema	**Y N** Fainting/Epilepsy/Seizures	**Y N** Artificial Bones/Joints
Y N Heart Murmur	**Y N** Tuberculosis	**Y N** Liver Problems	**Y N** Neck Surgery
Y N Heart Surgery	**Y N** Asthma	**Y N** Hepatitis	**Y N** Sinus Problems
Y N Heart Disease	**Y N** Difficulty Breathing	**Y N** Kidney Problems	**Y N** Jaw Problems
Y N Artificial Valves	**Y N** Respiratory Problems	**Y N** Dialysis	**Y N** Severe/Frequent Headaches
Y N Pacemaker		**Y N** Cancer/Chemo	**Y N** Psychiatric Problems
Y N Congenital Heart Defect		**Y N** Leukemia	**Y N** Dementia/Alzheimers
Y N Mitral Valve Prolapse		**Y N** HIV/AIDS/ARC	
Y N High/Low Blood Pressure		**Y N** Thyroid Problems	
Y N Anemia		**Y N** Diabetes/Hypoglycemia	
Y N Bleeding Disorder			
Y N Rheumatic Fever			

If you answered "Yes" to any above questions, please explain: ____________________

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No

Please list any other medical conditions, surgeries, or hospitalizations you have had in the last 10 years: ____________

____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Codeine ❑ Dental Anesthetics ❑ Foods:____________________ ❑ Others:____________________

Do you use tobacco? ❑ Yes ❑ No

FOR WOMEN: Are you taking Birth Control pills? ❑ Yes ❑ No

Are you Pregnant? ❑ Yes/Weeks? __________ ❑ No Are you nursing? ❑ Yes ❑ No

Financial and Scheduling Policy:

1. Patients who have Dental Insurance will be required to pay their DEDUCTIBLE and ESTIMATED PORTION at the time services are rendered. You will also be responsible for any balance remaining after the insurance company has paid the claim Insurance checks and Explanation of Benefits (EOBs) mailed to patients must be brought to the office. If checks are not brought to the office, the balance will be patients responsibility.
2. Patients who do not have dental insurance will be required to pay the entire fee at each visit.
3. A 3% professional discount will be given on treatment over $2,250.00 if paid with **cash or check at the time of service.**
4. If we do not receive payment from your Insurance Company within 30 days, payment becomes your responsibility. Not all services are covered benefit in all contracts. You are responsible for the charges that insurance does not pay. In the event that the account is not paid in full after 30 days and we refer the account to collection, you will be responsible for all fees incurred for the collection of your bill (i.e. attorney fees, court costs and a collection/legal fee).
5. We accept Visa, MasterCard, Discover and American Express.
6. We have made arrangements with "Care Credit" to provide extended Payment Plans with zerero interest rates. Applications are available from our front office staff and a quick approval can be made.
7. Your appointment time is reserved just for you. We RESERVE THE RIGHT TO CHARGE $50.00 for all broken appointments or cancellations made without a 24 hour advance notice prior to your scheduled appointment.
8. After two broken appointments have been documented, you will be required to pay all broken appointment fees plus the estimated patient portion for your next appointment, prior to scheduling.

I HAVE READ THE ABOVE POLICIES AND AGREE TO ABIDE BY THEM.

Print Name: ____________________ Sign:____________________ Date:__________