Today's Date: _____

Patient Information

Name: _____ Birth Date: _____
Last First MI Nickname

Gender: ❒ Male ❒ Female **Family Status:** ❒ Married ❒ Single ❒ Other **Social Security Number:** _____

Address: _____
Street Apt # City State ZIP

Home Phone: _____ **Work Phone:** _____ ext _____

Cell Phone: _____ **E-mail address:** _____

Occupation: ❒ Homemaker ❒ Retired ❒ Full-time Student ❒ Other: _____

Employer & Address: _____

Responsible Party Information

Name: _____ Birth Date: _____
Last First MI Nickname

Relationship to Patient: ❒ Patient ❒ Spouse ❒ Parent ❒ Legal Guardian

Gender: ❒ Male ❒ Female **Family Status:** ❒ Married ❒ Single ❒ Other **Social Security Number:** _____

Address: _____
Street Apt # City State ZIP

Home Phone: _____ **Work Phone:** _____ ext _____

Cell Phone: _____ **E-mail address:** _____

Occupation: _____ **Employer & Address:** _____

Insurance Information

Primary Insurance:

Name of Insured: _____ **Is Insured a patient?** ❒ Yes ❒ No

Insured's Birth Date: _____ **Relationship to Patient:** ❒ Patient ❒ Spouse ❒ Parent ❒ Legal Guardian

Insurance: _____ **Group #:** _____ **ID#:** _____

Insured's Address (if different than patient's): _____

Secondary Insurance:

Name of Insured: _____ **Is Insured a patient?** ❒ Yes ❒ No

Insured's Birth Date: _____ **Relationship to Patient:** ❒ Patient ❒ Spouse ❒ Parent ❒ Legal Guardian

Insurance: _____ **Group #:** _____ **ID#:** _____

Insured's Address (if different than patient's): _____

Referral Information

Whom may we thank for referring you to our practice? Please give us their name, so we can thank them!

❒ Another patient ❒ Newspaper ❒ Postcard ❒ Letter ❒ Insurance ❒ Friend/Relative ❒ Other: _____

Name of Person or office who referred you: _____

CHILD HEALTH HISTORY

Patient's Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Date of last physical exam: _____

Home Phone: _____ Mother's cell: _____ Father's cell: _____

Pediatrician's name: _____ Telephone Number: _____

Is the patient allergic to, or has he/she had an adverse reaction to, any of the following:

- ❒ Aspirin
- ❒ Codeine
- ❒ Ibuprofen
- ❒ Sulfa
- ❒ Antibiotics
- ❒ Erythromycin
- ❒ Latex
- ❒ Local Anesthetics
- ❒ Soy
- ❒ Eggs

Other (please describe): _____

What type of allergic reaction happens?

❒ Rash/hives ❒ Breathing problems/wheezing ❒ Swelling ❒ Itching

Is the patient in good health? ❒ Yes ❒ No

Have there been any changes in his/her health in the past year? ❒ Yes ❒ No

Has the patient had any serious illness, operation or been hospitalized? ❒ Yes ❒ No

If yes, for what condition(s)? _____

Was the patient born prematurely or were there complications at birth? ❒ Yes ❒ No

Has the patient ever been told to take antibiotics prior to dental visits? ❒ Yes ❒ No

Has the patient ever had complications following dental treatment? ❒ Yes ❒ No

List any medications currently being taken by the patient, including vitamins & herbs: _____

_____

Dental History

Date of last visit to the dentist: _____ For what service? _____

Any dental complaints or problems? ❒ Yes ❒ No

Does he/she brush teeth daily? ❒ Yes ❒ No

Does he/she floss daily? ❒ Yes ❒ No

Any injuries to mouth or teeth? ❒ Yes ❒ No

Any unhappy dental experiences? ❒ Yes ❒ No

Is fluoride taken in any form? ❒ Yes ❒ No

Any mouth habits, such as thumb sucking, sleeping with bottle, pacifier or nail biting? ❒ Yes ❒ No

If yes to any question, please explain: _____

_____

PLEASE CONTINUE ON PAGE TWO

CONSENT FOR SERVICES

Welcome! We are excited that you have chosen our office to help you to great oral health. We appreciate the trust you have placed in us, and we will do our best to provide the high-quality dental care that you expect and deserve. We believe you should receive prompt attention and excellent service. We believe a satisfied patient returns for additional services and refers others to the office that they feel would benefit from our services.

By signing, you hereby authorize the Doctors and/or their assignees to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of your dental needs. Additionally, you give permission for such items to be used for purposes of research, education, marketing or publication in professional journals. In addition, unless you notify our office otherwise, we may use your written comments in material to promote _____ and/ or the Doctors.

By signing, you hereby authorize the Doctors and/or their assignees to perform any and all forms of treatment, medication and therapy that may be indicated. By signing, you also indicate your understanding that the use of anesthetic agents embodies a certain risk.

By signing, you hereby authorize _____, the Doctors and/or their assignees to release information to third party payers about your treatment, and to other health practitioners involved in your care.

By signing, you hereby agree to assign all insurance benefits to _____ and/or the Doctors.

By signing, you hereby grant your permission to _____ and the Doctors or their assignees to contact you at home or at work to discuss matters related to your care.

I have read and understand the above conditions and agree to their content.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Printed Name of Patient or Representative Relationship to Patient

Emergency Contact: In the event of an emergency, whom should we contact?

_____ _____ _____
Name Relationship Phone Number

FINANCIAL POLICY

Thank you for choosing us to provide your dental care. We place a high priority on the dental health of our patients and our goal is for you to enjoy the benefits of a comfortable, functional and attractive smile. We've found that a clear understanding of our financial policy in advance of your dental care helps to relieve some of the anxiety associated with dental visits. Please read the following carefully and ask us any questions you might have. We will do our best to answer them for you.

Patients with Insurance:

It's important to remember that your insurance coverage is a contract between you and your insurance company. Benefits and coverage vary significantly from plan to plan. Please keep in mind that insurance is not designed to provide a 100% benefit, but rather is meant to assist you with your investment in dental care. The cost of treatment is your responsibility regardless of your insurance coverage.

As a courtesy to our patients, we are happy to submit claims to your insurance company. In order to do this, you must provide us with accurate and up-to-date insurance information. We will verify your coverage before treatment and we will ***estimate*** the portion insurance will cover and your co-payment, including deductibles. This co-payment is due on the day of treatment unless other arrangements have been made ahead of time. This amount will be an estimate only, so there may be an additional balance due after payment from your insurance company. You are responsible for any such remaining balance.

For your convenience, we accept cash, checks, Visa, MasterCard, Discover and American Express.

Patients without Insurance:

Payment is expected at the time of service unless *prior* financial arrangements have been made. As noted above, we accept cash, checks, Visa, MasterCard, Discover and American Express. We also accept Care Credit, which is an outside healthcare financing program that offers several payment plans upon approval.

If your total charges exceed $500, we may also offer financing arrangements. These arrangements must be made in advance of treatment being provided.

- You can elect to pay 50% of your bill on the day of service and the remaining 50% within 30 days. This requires the you to provide credit/debit card information to enable us to process the second payment. *Interest will not be assessed for this option.*
- You can elect to pay 1/3 of your treatment on the day of service, 1/3 in 30 days and the final 1/3 in 60 days. Interest of 1.5% per month (18% per year) will be assessed for this option.

- You can also elect to pay your balance in 6 monthly installments. An interest rate of 1.5% per month (18% per year) will be assessed. Payments will be accepted only by debit/credit cards or via electronic transfer of funds (ACH) from a checking/savings account.

Statements will be sent monthly as a reminder. However, *it is your responsibility to plan ahead for debit/credit card transactions we process.* A late fee of $20.00 per occurrence will be assessed to your account if scheduled amounts are not paid by the due date.

Discounts:

- Cash Discount: We offer a 5% discount for payments you make by cash or check.
- Senior discount: We offer a 5% discount to our patients over 65.
- Military/Veterans Discount: We are pleased to honor those who have served our country with a 5% discount.

Returned Check Fees:

The fee for a returned check is $35.00 per occurrence. You will not be allowed to write another check until the full amount (the original amount plus the $35.00 fee) is paid. Another incident may result in losing the privilege of paying by check again.

Minor Patients:

If you have a child under 18, please plan to be present at his or her appointment. If you are unable to attend, please call our office prior to the visit to take care of any necessary financial arrangements. In the case of divorced parents, please remember that the parent bringing the minor child is responsible for payment of the child's treatment, regardless of any custodial decrees.

Missed Appointments:

We understand that sometimes it is necessary to change your appointment. If you need to reschedule an appointment, please give us at least 48 hours advance notice. Missed appointments are costly for us all and may prevent us from assisting another guest. Please be aware that failed appointments, or those cancelled with less than 48 hours notice, may incur a $50.00 missed appointment fee.

I have read and understand the above conditions and agree to their content.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____ _____

Printed Name of Patient or Representative Relationship to Patient