Patient Name (first, middle, last)	Date	
Sex: M F	Home Phone:	Birth Date:
Address:	Business Phone: Cell Phone: E Mail Address:	
Single□Married□Separated□Divorced□Widowed□		
Person responsible (if minor),	Social Security #	
Employer:	Occupation:	How long?

Preferred method of contact: Home Phone Work Phone Cell Phone Email

Spouse's name:	Birth Date:
Spouse's Social Security #:	Occupation:
Spouse's Employer:	Spouse's Business Phone:

Pharmacy:	Pharmacy Phone:	
Nearest relative not living with you:	Relationship:	Phone:
Person financially responsible:	Payment by: □Cash □Check □Credit or Debit card	
Drivers License#		
Whom may we thank for referring you?		

Patients with dental insurance- fill out information below:

Primary Insurance:	Policy Holder Name/Birthdate:
Claims Address:	Member ID#
Phone #	Group #

Secondary Insurance:	Policy Holder Name/Birthdate:
Claims Address:	Member ID#
Phone #	Group#:

(Patients will be expected to pay the estimated co-payment and /or deductibles (if applicable) the day services are rendered. We will submit the claim and wait for reimbursement. However, if the claim is not paid in 45 days, the balance becomes due and the patient will await reimbursement from their insurance company.

DENTAL HISTORY

Last Dental Visit:	Last Dental x-rays:
Previous Dentist Name:	Previous Dentist Phone:
How do you feel about your teeth?	Are you having a dental problem now? Is your present dental health poor?
Have you had periodontal (gum) treatment?	Have you ever had a bad dental experience?
Have you ever worn braces?	Do you have any missing teeth?
Do you have any loose, tipped or shifting teeth?	Have you had a lot of dental work in the past?
Are your gums tender or bleeding?	Do you grind your teeth?
Do you have headaches, earaches or neck pain?	Do you have sensitivity to hot, cold or sweets?
Do you want your smile to look better or different?	Do you have problems with fillings breaking?
Do you have discolored teeth that bother you?	Do you floss regularly?
Do you wear dentures? If yes, are you happy with them?	Are you interested in non-removable replacements for your missing teeth?

MEDICAL HISTORY

Physician Name: Physician Phone:	Have you had any recent surgery/hospitalization? Do you take aspirin daily? Do you take oral contraceptives or hormones?
Are you pregnant or nursing?	Do you smoke or chew tobacco?
Do you take any prescription, non-prescription medications or herbal supplements? If yes, please list:	
Please list any prescription or non-prescription medications you are allergic to:	

Please circle Y or N for any of the following conditions, past or present:

Y N	Heart murmur	Y N	Latex allergy
Y N	Heart disease or attack	Y N	Epilepsy or seizure disorder
Y N	Angina	Y N	Fainting or dizziness
Y N	Scarlet or Rheumatic fever	Y N	Psychiatric treatment
Y N	Heart surgery	Y N	Blood transfusion
Y N	Pacemaker	Y N	Cancer, chemo or radiation treatments
Y N	Congenital heart defects	Y N	Glaucoma
Y N	High blood pressure	Y N	Pigment lesions
Y N	Unexplained weight loss	Y N	Bruise easily
Y N	Liver or kidney disease	Y N	Asthma or Sinus Trouble
Y N	Hepatitis	Y N	Emphysema
Y N	Stroke	Y N	Tuberculosis
Y N	Anemia	Y N	Allergies or hives
Y N	Artificial joints (pins, plates, screws)	Y N	Diabetes
Y N	HIV or AIDS	Y N	Thyroid disease
Y N	Osteoporosis	Y N	Arthritis
Y N	HPV	Y N	Cold Sores / Fever Blisters

Signature: **Date:**

OFFICE FINANCIAL AND INSURANCE POLICY

Our fees are meant to be fair and reasonable. We strive to keep them that way. You assist that effort when you pay for services at the end of each visit. Our office manager can tell you the approximate fee for treatment before your appointment. To make payments convenient for you, we accept cash, personal checks, Visa, Master Card, Discover, Debit cards and Care Credit. A monthly charge of $5.00 or 1.5% whichever is greater, will be applied to balances 30 days past due.

We will submit claims for our patients who are covered by dental insurance plans. Insured patients should read their policies carefully to become familiar with its benefits and limitations. It is important that you understand that in most cases your insurance is designed to reduce your cost, not to eliminate it completely. You are ultimately responsible for the full amount of your bill regardless of your insurance coverage.

Patients with insurance are expected to pay any estimated deductibles and co-payments at the time of service. Any difference will be billed to you after the insurance payment has been received. In the case of a credit balance over $50, we will send a refund unless otherwise instructed. If payment has not been received from the insurance company after 45 days of filing a claim the balance becomes the immediate responsibility of the patient.

Any checks returned to our office are subject to an additional fee of $30.00. Immediate remittance in the form of cash, money order or certified funds is expected.

There is a charge for broken appointments without at least 24 hours notice.

If, at any time, you have a question about this policy or your account, please do not hesitate to contact our office manager. I have read the above policy and agree to accept financial responsibility.

I authorize the release of any information necessary to process my claim.

I do assign ( ) OR do not assign ( ) insurance benefits to be paid to my dental office.

I understand I am responsible for payment for any services I have received that are not covered by or that are denied by my insurance company.

If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court costs, and attorney fees.

_____ _____

Signature of Patient and/or Guardian (SEAL) *Date*