PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name: _____
Last First MI (Preferred)

Birthdate: _____ SS #: _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Work Phone: _____ Wireless Phone: (_____

Email: _____

Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Preferred Contact Method for Confirmations: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Preferred Contact Method for Recall: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Student status if dependent over 19 (for ins) ☐ Non Student ☐ Full Time ☐ Part Time

How did you hear about us?

_____

(If someone referred you here, please enter their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family: ☐

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

INSURANCE POLICY 1

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Chest pain (angina)	Yes / No Blood in stools	Yes / No Frequent vomiting
Yes / No Fainting spells	Yes / No Diarrhea or constipation	Yes / No Jaundice
Yes / No Recent significant weight loss	Yes / No Frequent urination	Yes / No Dry mouth
Yes / No Fever	Yes / No Difficulty urinating	Yes / No Excessive thirst
Yes / No Night sweats	Yes / No Ringing in ears	Yes / No Difficulty swallowing
Yes / No Persistent cough	Yes / No Headaches	Yes / No Swollen ankles
Yes / No Coughing up blood	Yes / No Dizziness	Yes / No Joint pain or stiffness
Yes / No Bleeding problems	Yes / No Blurred vision	Yes / No Shortness of breath
Yes / No Blood in urine	Yes / No Bruise easily	Yes / No Sinus problems

Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Family history of heart disease	Yes / No Surgeries	Yes / No Osteoporosis
Yes / No Heart attack	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Artificial joint	Yes / No Diabetes	Yes / No Asthma
Type/ Date of surgery: _____		
Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Heart defects	Yes / No Tumors or cancer	Yes / No Sexually transmitted disease
Yes / No Pacemaker		
Date implanted: _____		
Yes / No Heart murmurs	Yes / No Chemotherapy	Yes / No Herpes
Yes / No Rheumatic fever	Yes / No Radiation	Yes / No Canker or cold sores
Yes / No Skin disease	Yes / No Arthritis, rheumatism	Yes / No Anemia
Yes / No Hardening of arteries	Yes / No Emphysema or other lung disease	Yes / No Liver disease
Yes / No High blood pressure	Yes / No Kidney or bladder disease	Yes / No Eye disease
Yes / No Seizures	Yes / No Stroke	Yes / No Transplants
Yes / No Cosmetic surgery	Yes / No Eating disorders	Yes / No Tuberculosis

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please circle Yes or No for each)

Yes / No Aspirin	Yes / No Valium or sedatives	Yes / No Codeine or other opioids
Yes / No Penicillin or other antibiotics	Yes / No Latex	Yes / No Food
Yes / No Nitrous oxide	Yes / No Local anesthetic	Yes / No Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

(Please circle Yes or No for each)

Yes / No Recreational drugs	Yes / No Tobacco in any form	Yes / No Antibiotics
Yes / No Over-the-counter medicines	Yes / No Alcohol	Yes / No Supplements
Yes / No Weight loss medications	Yes / No Bisphosphonate (Fosamax)	Yes / No Aspirin
Yes / No Antidepressants	Yes / No Herbal supplements	

Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If YES, please explain reason: _____

Please list all prescription medications: _____

VI. ALL PATIENTS (Please circle Yes or No for each, as applicable)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

_____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you tested positive for COVID-19?

If YES, date of positive test result: _____

Yes / No Are you experiencing any ongoing or lasting symptoms or effects as a result?
If YES, what are these symptoms or effects? _____

Yes / No Are you currently under the care of a physician or taking any medications for any of the conditions listed above?
If YES, please list _____

_____

Yes / No Are you or could you be pregnant? If YES, how many months?

Yes / No Are you nursing?

If patient answers "yes" to any of the questions above, consider seeking additional information from the patient regarding their symptoms and medications, prior to treatment.

Yes / No **Are there any issues or conditions that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?):

Name: _____ **Relationship:** _____ **Phone Number:** _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____	_____	_____	_____
Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OFFICE AND PAYMENT POLICIES FORM

IMPORTANT: Do not sign this form without reading and understanding its content. Please initial each section to idicate you have read and understand it.

_____Insurance-If you are not covered by any dental insurance plan, full payment of all office visits and other service charges is expected at the time services are provided. If you are covered by insurance, you are responsible for your portion as determined by your insurance plan. If our estimate of your portion is less than the amount determined by your plan, an adjustment to your account will be made and remain as a credit to your account for you to use and not transferable to another account. If our estimate of your portion is more than the amount determined by your plan, a statement of balance due will be sent to you along with insurance explanation of coverage and is due upon receipt.**Please note We do the best to give you the most accurate estimate using your insurance benefits that are given to us by your insurance**

_____Charges for all services rendered are the responsibility of the patient, whether or not covered by insurance. As a courtesy, we will file only dental insurances claims for our patients to the insurance we have on file that gets provided to us by you. It is the patients responsibility to provide the office with their insurance information. If the patient is covered under multiple plans, it is the patients responsibility to inform our office, and of any changes to their insurance. Our office will not submit any claims to the patients medical insurance. All patient payments, non-covered service charges, and deductibles are required by your insurance, are due at the time of service.

_____We rely on the insurance information you give us in filing insurance claims for you. If we dont not have correct insurance information at the time of service, we may not be able to file your claim before the "Timely Filing" period ends. If the insurance information that you provide us is not accurate, you will be liable for the full amount of all charges and agree to pay these charges in full.

_____Each insurance plan has a different set of procedures that are eligible for payment, and may have limits on the number and timing of visits, x-rays, and procedures. Our office only provides estimates based on the information we receive from your insurance. No insurance gurantees payment. Insurnace determines payment once they receive the claim for services rendered. Many factors can play a role in denial for payment from the patients insurance. Some examples are the amount of benefits remaining, whether or not the patients deductible has been met, any waiting period on the plan, or if coverage is lower than average. If your insurance company does not pay for any services rendered in our office, you accept responsability for full payment of these charges. Charges for certain procedures must be paid for by you prior to having the services provided.

Regulations mandate that insurance companies pay for undisputed claims within 30 days of submission. We will allow 45 days for your insurance to pay a claim. If you insurance company has not paid in full by this time, you will be responsible for all outstanding charges. Please follow up with your insurance company to make sure they pay your claims. We will credit any overpaid amount to the paitent account or refund insurance company as appropriate.

- Payment-We accept Cash,Credit Cards,HSA,Checks and we participate with Care Credit patient financing.

- Account Credits-If you or one you family members has a credit on their account, they will not be transerfable to use for anyone else.

- Delinquent Accounts-Once we have exhausted our internal efforts to obtain payment for services, we will refer accounts to an outside collection agency. These agencies report delinquent accounts to credit reporting services. You will be charged and agree to pay a $50 fee and for all collection and /or attorneys fees that we may incur trying to collect on your account.

- Returned checks-Occasionally, a check written to us is returned unpaid. Returned checks must be paid in full within 10 days of notification plus a $40 fee and must be paid in cash.

- Scheduling-Patients who do not show up for an appointment or cancel with less than 48 hours valid notice may be billed and agreess to be responsible for full payment of $50 charge. Patients who do not show up to appointmetns scheduled for treatment or patients who cancel their appointments for treatment without 48 hours valid notice, will result in a $65 per hour charge due to the amount of time shceudled and advance planning required. And for patients scheduled with our specialty doctors and who do not show up or cancel with less than 48 hours valid notice will be charged $75 per hour due to the amount of time scheduled and advance planning required.**Valid Notice means speaking to an office staff member during business hours and not by leaving a voicemail**

- I have read, understand and agree to the Office and Payment Policies as stated above. This consent will remian valid indefinitely.

_____ _____

PATIENTS FIRST AND LAST NAME PRINTED PATIENT SIGNATURE

_____

DATE