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:_____

_____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't Know

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

Y N Heart Attack/Stroke	Y N Thyroid Problems	Y N Cancer/Chemotherapy	Y N Heart Surgery	Y N Kidney Problems
Y N Heart Murmur	Y N Liver Problems	Y N Hepatitis	Y N Rheumatic Fever	Y N Respiratory Problems
Y N HIV+/AIDS/ARC	Y N Asthma	Y N Mitral Valve Prolapse	Y N Sinus Problems	Y N Difficulty Breathing
Y N Artificial Valves	Y N Artificial Bones/Joints	Y N Diabetes/Hypoglycemia	Y N Heart Disease	Y N Psychiatric Problems
Y N Emphysema	Y N Leukemia	Y N Congenital Heart Defect	Y N Fainting/Seizures/Epilepsy	Y N Anemia
Y N Tuberculosis TB	Y N Frequent Neck Pain	Y N Bleeding Problems	Y N High/Low Blood Pressure	Y N Jaw Problems(TMJ/TMD)
Y N Pacemaker	Y N Severe/Frequent Headaches			

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

Please list any other medical conditions you have or ever had: _____

_____

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

Do you use tobacco? ❑ No ❑ Yes

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

Are you Pregnant? ❑ No ❑ Yes/Weeks? _____ 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 5% Professional Discount on treatment over $1500.00 paid with **cash** or **check** will be given when **paid in full** on the day the appointment is **scheduled**.
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 zero 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 without giving us 24 hour advance notice prior to your schedule appointment.

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

Print Name: _____ Sign:_____ Date:_____