PATIENT INFORMATION

First Name: ____________________________M.I.______ Last Name:_____________________ Preferred Name:_________________

Sex: ☐F ☐M ***Date of Birth***:__________________ Soc. Sec.#_________________________ Driver's Lic.#_________________

Email ____

Address____ City:_______________________ State:________ Zip:____________

Hm # (_____)______-________________ Wk # (_____)______-____________Ext._______ Cell (______)______-__________

Patient/Parent Employer____

Present Position:_______________________________________ How long held:___________

Referred by: ☐Website ☐Location ☐Patient ☐Other____________________ **Emergency Contact** ____________________

METHOD OF PAYMENT: Payment in full or estimated insurance co-payment is to be paid in full at each appointment.

I will pay today's charges in full by: ☐ Cash ☐ Check ☐ Credit Card ☐ Other ☐ Financing

*ALL UNPAID CHARGES WILL BE SUBJECT TO FINANCE CAHRGES, ADMINISTATION FEES AND LEGAL COSTS INCURRED DURING COLLECTIONS

Who is responsible for the account? ☐Self ☐Spouse ☐Father ☐Mother ☐Other__________________________

Name:___________________________________ Soc. Sec. #__________________________ D.L.#___________________________

Hm Tel.# (_______)_______-________________Cell # (_________)_________-_____________

Address:____ City:_________________________ State:_______ Zip_____________

Employer:____Tel.:(_______)________-_____________

Insurance Information

Patient: Student: ☐Full Time ☐Part Time School Name_____________________________________

☐Married ☐Divorced ☐Widowed ☐Single ☐Child

Dental Insurance

Employer:____

Employer Phone #:_____________________________________

Subscriber Name:____________________________________

Subscriber Date of Birth:_______________________________

Subscriber I.D./S.S #:__________________________________

Ins. Co.:_____________________**Tel #:**__________________

Address: ____

City ____________________State ___________Zip ________

Group #___________________________________

Secondary Dental Coverage

Employer:____

Employer Phone #:_____________________________________

Subscriber Name:____________________________________

Subscriber Date of Birth:_______________________________

Subscriber I.D./S.S #:__________________________________

Ins. Co.:_____________________**Tel #:**__________________

Address: ____

City ____________________State ___________Zip ________

Group #___________________________________

Dental History

Do you have specific dental problems? Y☐N☐ If yes, please explain____

Do you have dental examinations on routine basis Y☐N☐

Do you brush and floss daily? Y☐N☐ Do your gums ever bleed? Y☐N☐

Do you want to keep your remaining teeth? Y☐N☐

Do you ever have clicking popping or discomfort in the jaw joint? Y☐N☐

Do you clinch or grind your teeth? Y☐N☐ If yes, please explain____

Have your past dental experiences been positive? Y☐N☐ If yes, please explain____

Do you smoke or chew? Any sore spots or growths in your mouth? Y☐N☐ If yes, please explain_________________________________

Name of previous dentist (optional):____

When was the last time you had a full mouth series of x-rays taken?____

Medical information

Reason for today's office visit:____

Name of your Physician:____Phone:___________________________

Have you had any illness, operation or been hospitalized in the past five years? ____________________________

____

Are you taking any medication?_______ Please List____

Are you allergic to any medications or substances? ☐ Latex ☐Penicillin ☐Codeine ☐Sulfa ☐Aspirin

☐Acrylic ☐Metal ☐Other______________________

Women Pregnant/trying to get pregnant Y☐ N☐ Nursing Y☐ N☐ Taking oral contraceptives Y☐ N☐

Health History form has been completed and reviewed.

Signature of Staff: ____**Date:**_______________________________

I Certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any member if his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient: (Parent or Guardian if minor) **X**____ **Date:** ___________________________

Fees & Payment

We make every effort to keep down the cost of your dental treatment. You can help by paying upon completion of each visit. An estimate of the charge for any procedure you may require will be given to you upon request. If you have dental insurance we will be glad to fill out the proper forms and file them, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge**. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys' fees, and court costs.**

Also 20% of total estimated treatment cost is required as a non-refundable down payment at the time you schedule your treatment. The balance is due at the time your treatment is performed.

Signature of Patient: (Parent or Guardian if minor) **X**____ **Date:** ___________________________

Authorization

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of Patient: (Parent or Guardian if minor) **X**____ **Date:** ___________________________

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of Patient: (Parent or Guardian if minor) **X**____ **Date** ___________________________