PATIENT INFORMATION SHEET

Date: _____ E-mail:_____ Referred by:_____

Patient Name: _____SSN:_____Birthdate:_____

Address:_____C/S/Z:_____

Home Phone:_____Mobile#:_____Sex: M F Marital: M S W D

Employer:_____Phone#:_____Occupation:_____

Spouse:_____SSN:_____Birthdate:_____

Employer:_____Phone#:_____Occupation:_____

Emergency Contact:_____Relationship:_____

Address:_____Phone#:_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of Responsible Person:_____Relationship:_____

Address:_____C/S/Z:_____

Home Phone:_____Mobile#:_____SSN:_____

Employer:_____Phone#:_____Occupation:_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insured's Name:_____SSN:_____Birthdate:_____

Patient's Relationship to Insured: Self_____ Spouse_____ Child_____ Other_____

Employer:_____Phone#:_____

Insurance Co:_____Subscriber ID:_____

Claims Address:_____Phone#:_____

SECONDARY INSURANCE

Insured's Name:_____SSN:_____Birthdate:_____

Patient's Relationship to Insured: Self_____ Spouse_____ Child_____ Other_____

Employer:_____Phone#:_____

Insurance Co:_____Subscriber ID:_____

Claims Address:_____Phone#:_____

HEALTH HISTORY

DENTAL INFORMATION

What is the reason for your dental visit today? _____

Do your gums bleed when you brush/floss? Y N
Are your teeth sensitive? Y N
Does food or floss catch between teeth? Y N
Is your mouth dry? Y N
Have you had periodontal(gum) treatments? Y N
Have you ever had orthodontic treatment? Y N

Do you have any clicking, popping or discomfort in the jaw? Y N
Do you grind your teeth? Y N
Do you have sores or ulcers in your mouth? Y N
Do you wear dentures or partials? Y N
Have you ever had a serious injury to your head or mouth? Y N
Are you currently experiencing dental pain or discomfort? Y N

Have you had any problems associated with previous dental treatment? _____

Date of last dental exam:_____ Date of last dental x-rays:_____

How do you feel about your smile?_____

MEDICAL INFORMATION

Are you in good health? Y N
Has there been any change in your general health within the past year? Y N
If yes, what condition is being treated?_____
_____

Have you had a serious illness, operation or been hospitalized in the past 5 years? Y N
If yes, what was the reason?_____
_____

Are you currently taking any prescription drugs? Y N If yes, please list them:
_____

Are you taking, or have you taken any diet drugs such as Phen-fen or Redux? Y N
Are you taking Fosamax or Actonel for Osteoporosis or Paget's disease? Y N

Do you use tobacco? Y N
Do you use alcohol or controlled substances? Y N
Have you had an orthopedic total joint replacement? Y N
If yes, what was the date? _____

WOMEN ONLY: Are you:

Pregnant? Y N Nursing? Y N Taking birth control or hormonal replacement? Y N

ALLERGIES – Are you allergic to or have you had a reaction to:

Local anesthetics Y N	Aspirin Y N	Penicillin Y N	Barbituates Y N
Sulfa Drugs Y N	Metals Y N	Latex Y N	Iodine Y N

Do you currently or have you had any of the following diseases or problems:

Heart murmur……Y N	Anemia……Y N	Chest pains……Y N	Neurological disorders……Y N
Mitral valve prolapse……Y N	Blood Transfusion……Y N	Chronic pain……Y N	If yes, specify:_____
Artificial heart valves……Y N	If yes, date:_____	Diabetes Type I/II……Y N	Mental health disorder……Y N
Rheumatic fever……Y N	Hemophilia……Y N	Eating disorder……Y N	If yes, specify:_____
Cardiovascular disease……Y N	Aids/HIV infection……Y N	Malnutrition……Y N	Recurrent infection……Y N
Angina……Y N	Arthritis……Y N	Gastrointestinal disease……Y N	Type of infection:_____
Arteriosclerosis……Y N	Autoimmune disease……Y N	Reflux/heartburn……Y N	Kidney problems……Y N
Congestive heart failure….Y N	Rheumatiod arthritis……Y N	Ulcers……Y N	Night sweats……Y N
Coronary Artery disease….Y N	Lupus……Y N	Thyroid problems……Y N	Osteoporosis……Y N
Damaged heart valves……Y N	Asthma……Y N	Stroke……Y N	Swollen Glands……Y N
Heart attack……Y N	Bronchitis……Y N	Glaucoma……Y N	Headaches/migraines……Y N
High blood pressure……Y N	Emphysema……Y N	Hepatitis……Y N	Severe/rapid weight loss…..Y N
Congenital heart defect….Y N	Sinus trouble……Y N	Jaundice……Y N	Sexually transmitted dis……Y N
Pacemaker……Y N	Hayfever……Y N	Liver disease……Y N	Excessive urination……Y N
Rheumatic heart disease…Y N	Tuberculosis……Y N	Epilepsy……Y N	
Abnormal bleeding……Y N	Cancer/chemo……Y N	Fainting spells……Y N	

Do you have any disease, condition or problem not listed above that we should know about? _____

Signature:_____ **Date:** _____

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time of service, unless payment arrangements have been approved in advance by our staff. We accept cash, check, Visa, MasterCard, American Express, Discover, and outside financing. We will be happy to help you process your insurance claim form for your reimbursement. A completed insurance form must accompany any such request at each visit.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Most insurance companies have a deductible that must be met before the company will pay their portion. If you have not met your deductible for the year, you are responsible for any charges until the deductible is met. Even after the deductible is met, most companies only pay a percentage (such as 50% or 80%) and you will be responsible for the remainder.
3. Not all services are a covered benefit in all contracts. Insurance companies may arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers our relationship is with you, not your insurance provider. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If you have any questions, PLEASE do not hesitate to ask us. We are here to help you.

WHO IS FINANCIALLY REPSONSIBLE FOR THIS BILL? _____
PAYMENT OPTIONS:

1. Pay in full with CASH, CHECK, or CREDIT CARD. Receive a 10% discount on the total.
2. Half down to start, then the remainder paid in equal payments over a 3-month period with a recurring payment each month.
3. Extended payment plans from 12-60 months through outside financing.

Signature: _____ Date: _____

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A monthly service charge at a fixed rate of 1.5% per month/18% per annum* of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection fee charged by the collection agency to whom a delinquent account is assigned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

_____ _____

Signature of Patient, parent or guardian **Date**

Relationship to Patient _____

(Rev.4/10)

*The interest rate charged may be at the discretion of your office or accountant.

CONSENT TO PROCEED

I authorize Dr._____and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with standard dental preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:_____

Signature:_____ **Date:**_____
(Patient, legal guardian or authorized agent of patient)

Witness:_____ **Date:**_____