

ABOUT YOU

Mr. Mrs. Miss Ms. Dr. Minor
 Patient Name _____
 Name you like to be called _____
 Street Address _____
 City _____ State _____ Zip _____
 Home Phone _____
 Work Phone _____
 Cell Phone _____
 Best number to reach you? _____
 Employer _____
 Occupation _____
 Birthdate _____ Male Female
 Social Security Number _____
 Email Address _____

Today's date _____
 Referred by _____
 Name of general dentist _____

In case of emergency, please contact:

Name _____
 Relationship _____
 Work phone _____ Home phone _____

Person responsible for your bill _____
 Relationship to patient _____

PREFERRED PHARMACY _____
 PHARMACY NAME _____
 CROSS STREETS _____

How did you find our office?

General Dentist Friend Internet Phone book

DENTAL INSURANCE

Do you have dental insurance? Yes No
 Dental Insurance company _____
 Group number _____
 Insurance company phone # _____

Person with primary coverage _____
 Their birthdate _____
 Their employer _____
 Their Social Security or ID# _____

MEDICAL HISTORY

Are you currently under the care of a physician? Yes No
 If yes, please explain _____

Physician's name and phone number _____

Are you currently taking any medications or herbal supplements? Yes No
 If yes, please list medications and/or supplements and doses per day _____

Are you pregnant or breast feeding? Yes No Due date _____

If applicable, are you taking birth control? Yes No

Do you require antibiotics for joint replacements or heart conditions prior to dental treatment? Yes No

Have you ever taken any bone density related treatment medications? (ie. bisphosphonates) Yes No

Have you ever had an abnormal response to dental treatment or dental anesthetic? Yes No

Are you allergic to any of the following?

Penicillin/ Amoxicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Doxycycline/ Tetracycline	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sulfa drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Erythromycin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No	Codeine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Are you allergic to any other drugs or substances? Yes No

If yes, please list _____

Do you have or have you ever had any of the following diseases or medical conditions? (If yes, please describe details)

Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker/Defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart defect	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arrhythmia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema/ COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus/ Ear problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have or have you ever had any of the following diseases or medical conditions? (If yes, please describe details)

Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer/ Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____
Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression/ Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches/ Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypo/Hyperthyroidism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No Type _____
Ulcers/ colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when? _____	
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when? _____	
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type? _____ and what year was it diagnosed? _____	
Any other medical condition not listed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list. (space provided also to describe conditions from list above) _____	

SIGNATURE _____	DATE _____
SIGNATURE _____	DATE _____
SIGNATURE _____	DATE _____

ACKNOWLEDGEMENT OF PRIVACY RIGHTS

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third-party payers for my health care services
3. Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices*, and that I may contact this office to obtain a current copy of the practices.

I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that the office is not required to agree to my requested restrictions, but if the office does agree then it is bound to abide by such restrictions.

Patient Name (PRINT) _____ Date _____
Signature _____
Relationship to Patient _____

INTRODUCTION QUESTIONNAIRE

PLEASE CIRCLE YES OR NO

Has anyone every encouraged you to seek periodontal therapy before? YES NO

Has periodontal disease and therapy been explained to you? YES NO

If yes, when and by whom? _____

Do you know the meaning and importance of dental plaque and dental calculus (i.e. tartar)? YES NO

Have you ever had periodontal therapy? YES NO

If yes, when and why? _____

When was your last dental examination? _____

What was done as a result of that examination? _____

How often did you go to the dentist before then? _____

What has been your most common reason for going to the dentist? _____

Are you satisfied with your previous dental care? YES NO

Have you had any serious trouble associated with dental treatment? YES NO

If yes, explain _____

Have you had any teeth extracted (pulled)? YES NO

If yes, explain _____

Have you ever had endodontic therapy? (i.e. a root canal to remove the nerve from a tooth) YES NO

Have you ever had orthodontic treatment? (had your teeth straightened) YES NO

Has a dentist ever equilibrated your bite? (reshaped your teeth to make them fit together better) . YES NO

Has a dentist made you an appliance to protect your teeth from grinding or clenching forces? YES NO

If yes, do you wear it every night? YES NO

Would you consider yourself to be a good patient? YES NO

If not, why? _____

Has a dentist ever used anything to help you relax during a dental appointment? YES NO

If yes, what was used and how did you feel about it? _____

Are you satisfied with the appearance of your teeth? YES NO

Do you want to try to maintain your own teeth?..... YES NO

How do you feel about dentures? _____

Would it disturb you if you lost your teeth some day? YES NO

Are you aware that your diet can affect your teeth and your gums? YES NO

Do you eat refined carbohydrates (ie. Sugar, white bread, pastries, candy, cookies, Coke, etc.)? YES NO

Do you regularly eat foods from each of these categories: YES NO
Milk and dairy products, grain and cereals, meats, fruits and vegetables?

How would you assess your normal diet as far as nutrient content?GOOD FAIR POOR

Do you supplement your diet with vitamins, minerals, wheat germ, etc.? YES NO

Do you frequently or habitually smoke? YES NO

If yes, would you be willing to quit smoking in order to preserve your teeth? YES NO

Do you frequently or habitually drink alcoholic beverages? YES NO

Are you aware of a habit of grinding or clenching your teeth?..... YES NO

If yes, which habit _____ When do you clench or grind? _____

How long have you been aware of this habit? _____

Do you have any other oral habits (such as biting your fingernails, pencils, paper clips, thread, or pipe stems)?

INSURANCE AND FINANCIAL POLICY:

Please Initial

_____ We will gladly file an insurance claim to your primary insurance carrier for you. Please understand that insurance companies rarely reimburse the full amount, usually only paying between 30 to 50% after all deductibles have been met. 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 insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any balance not paid by your insurance company within 60 days after treatment.

_____ We will be happy to submit a pretreatment estimate to your insurance company. This usually takes four to six weeks to receive a reply. The portion you will pay will be the difference between our submitted fees and the amount the insurance company will pay, not the difference between their allowed fees and the amount they will pay.

_____ If we do not have a pretreatment estimate from your insurance carrier or you decide against having a pretreatment estimate submitted to your insurance carrier prior to your treatment or surgical procedure, we will require a 50% down payment at the time of service.

_____ Insurance companies do not routinely pay for more than two exams and cleanings per year. Therefore, we must collect for all exams and cleanings at the time of service.

_____ If you do not supply us with complete and accurate insurance information, you will be required to make payment in full for all services.

_____ Please understand that payment in full will be expected within 60 days of treatment even if your insurance has not paid. A finance charge of 1.5% (18%APR) will be assessed after that time on all remaining balances. Outstanding balances over 90 days will be turned over to a professional collection agency.

_____ Financial arrangements are individualized for every patient. Please speak to the office manager if you need to make other financial arrangements.

_____ There is a \$30.00 fee for any returned checks.

_____ I can read and understand English. My questions have been answered to my satisfaction.

The responsible party understands and agrees to the financial policy outlined above and will be responsible for all fees for treatment. The signature below is my authorization for release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Date	Signature of patient (or Guardian if minor)	Witness
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Non-Surgical Broken Appointment Policy

A broken appointment is defined as an appointment that is scheduled and not attended (no-show/no call) or is cancelled without at least **1 business day notice, we are closed on Fridays**. A fee of **\$75.00** will be assessed for each of the first **2** appointments that are broken. A fee of **\$150.00** will be assessed for the third broken appointment as well as for any subsequent ones that may occur. All broken appointment fees must be paid before any additional visits.

I have read and understand the broken appointment policy:

Printed Name	Patient Signature	Date
_____	_____	_____
_____	_____	_____
Date of B-Appt. #1	Patient Signature	Date
_____	_____	_____
_____	_____	_____
Date of B-Appt. #2	Patient Signature	Date
_____	_____	_____
_____	_____	_____
Date of B-Appt. #3	Patient Signature	Date

\$75.00 Fee

\$75.00 Fee

\$150.00 Fee