Chart #:_____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ (Cellular): _____ Best time to call:_____

E-Mail:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies
_____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Sleep Apnea
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
History of Smoking
☐ _____

· Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:_____

· Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain:_____

· Are you taking any medication? ☐ Yes ☐ No
Please list: _____

· Name of Physician: _____ Phone:_____

· Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Online ☐ Other Doctor ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

I understand that the office is not participating in any insurance plans and my insurance company will pay me, as the member, all insurance benefits for services rendered.

I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that the fee estimate listed for this dental care can only be extended for a period of ninety days from the date of the patient examination.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. Please be aware that in the event that your account is handed over to a collection agency you will be charged a fee anywhere between 33% and 50% of the account balance. You agree to reimburse us the fees of any collection's agency, which may be based on a percentage at a maximum of 50% of the debt, and all cost, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

I grant my permission to you or your assignee, to contact me to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

OFFICE POLICIES,
INFORMED CONSENT FOR TREATMENT, USE AND DISCLOSURE OF HEALTH INFORMATION

It's our goal to provide you with the highest level of aesthetically beautiful and functional dental care possible in a warm, personal, and attentive environment. We are committed to both improving your current dental health, and preventing future dental problems.

INITIAL DIAGNOSTIC PROCEDURES: In order to help formulate recommendations, the following diagnostic procedures may be performed:
(1) a medical and dental history, (2) discussion of your dental problems, concerns and desires, (3) x-rays, (4) plaster casts and/or digital models of the mouth and teeth, (5) examination of the mouth and associated structures, (6) photographs, and (7) conference with previous or concurrent treating health professionals. If additional diagnostic procedures or consultations are indicated, they will be discussed with you.

TREATMENT RECOMMENDATIONS: Are based on information gained from initial diagnostic procedures and previous experience and may vary for similar situations. The ultimate goal of treatment is to assist you in attaining optimum dental health and appearance. We will discuss with you the most appropriate and ideal treatment plan as well as reasonable alternative treatment plans. In those instances where supporting structures are compromised, recommendations can be made only after consultation with specialists. We will also inform you of the likely dental prognosis for each of these treatment plans and dental prognosis if no treatment is initiated at this time. You are welcome at any time to seek a second opinion. To provide you with optimal care, we must make our treatment recommendations based on the best available option to you. Unfortunately, most dental insurance provides coverage only for what they deem to be the minimally acceptable standard of care. We therefore will in no way allow insurance benefits to dictate treatment. Please note that our philosophy is to provide the most conservative treatment possible, leaving more invasive procedures (such as surgical or endodontic) as a last resort for restoring your dental health. In the event this approach does not bring satisfactory results, the next level or treatment will be offered. You will be responsible for the fees associated with every procedure that was performed.

REFERRAL TO OTHER SPECIALISTS: Dental restorative and prosthodontic treatment often requires concurrent treatment with other specialties such as: *Periodontics, Endodontics, Anesthesiology, Orthodontics, Oral Surgery, Physician (M.D.)*

ANESTHETICS: Most procedures are performed with local anesthetic (commonly referred to as *Novocaine)* In rare instances, allergic reactions may occur, so you are requested to inform our office staff of any known allergies you may have.

DENTAL TREATMENT DURING PREGNANCY: Elective procedures or procedures that can be easily postponed should generally wait until after childbirth. Treatment of dental pain and urgent procedures can be performed with relative safety to the fetus by minimizing the use of medications and avoiding the use of nitrous oxide and other medications with known fetal effects. Therefore, it is essential that you inform our staff of a confirmed or suspected pregnancy.

MEDICAL HISTORY: I understand the medical and dental history is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency. I will notify our staff of any change in my health or medication prior to treatment, at every visit.

TREATMENT: Upon diagnosis, I authorize Doctors or the designated staff person to perform all recommended and mutually agreed upon treatment employing all necessary assistance required for providing proper care.

INFORMED CONSENT AND AUTHORIZATION: I certify that I have read and understand this *Informed Consent,* which outlines the general treatment considerations as well as the potential problems and complication of dental treatment. I understand that potential complications and problems may include, but are not limited to, those described in this document and discussed with me. I understand that during and following the treatment, and in the future, conditions may become apparent that warrant additional or alternative treatment pertinent to the success of comprehensive treatment. Recognizing the potential problems and risks of dental treatment, authorization is given for dental treatment to be rendered by the dentist and office staff. I also approve any modification in design, materials or care, if it is felt this is for my best interest. This consent is in force indefinitely unless revoked by me in writing.

CONTACTS: I also give my permission to have the Dental office personally contact me and remind me of needed appointments through the means of communication that I have provided.

TERMS AND AGREEMENTS FOR CANCELLATIONS: All appointments are exclusively reserved**.** I hereby consent that, in the event that I may need to cancel my appointment, I will kindly give a twenty four hour prior to my appointment notice. If I fail to do so I am aware that I will be charged a $50.00 cancellation fee for every ½ hr that was reserved for me.

PAYMENT: I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made any fee quoted is guaranteed for ninety days only. For all prosthetic work involving laboratory fees payment is due at the time of the impression. We are not responsible for any fees associated with prosthetic work not delivered on time due to patient's failure to appear.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment payment, activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to use and disclose of my protected health information to carry our treatment, payment activities and health care operations. I have given the opportunity to ask any questions I may have regarding this Notice.

Signature:_____**Date:**_____
If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____Relationship to Patient_____

Dental Information

Previous Dentist Name and Phone number:

Date of most recent dental exam and dental x-rays:

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

Is there anything about the appearance of your smile that you would like to change?

Check all that apply:

- Had trouble getting numb
- Had any reactions to local anesthetic
- Had/have braces, orthodontic treatment
- You experience dry mouth
- Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- Food gets trapped between any teeth
- Have you ever whitened or bleached your teeth
- Have you experienced popping and/or clicking of your jaw joint
- You have difficulty chewing
- You clench or grind your teeth
- You wear or have worn a bite appliance
- Gums bleed when brushing or flossing
- Treated for gum disease or were told you have lost bone around your teeth
- Noticed an unpleasant taste or odor in your mouth
- Experienced gum recession
- Had any teeth become loose on their own (without injury)
- Experienced a burning sensation in your mouth
- You snore or wake up frequently during the night
- Have been diagnosed with sleep disorders
- Had complications from past dental treatment

If any of the checked boxes need further explanation, please describe: