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Welcome to our Practice

* = Must complete

***Patient Name:**

_____ _____ ____ _____
Last First MI Preferred Name

Title: _____ **Gender:** ☐ Male ☐ Female **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other
Mr./Ms./Mrs./etc.

* **Birth Date:** _____ **SS#:** _____

* **Address:** _____
Street

_____ _____ _____
City State Zip Code

Emai: _____

Phone: _____ _____ _____ _____
Home * Mobile Work Ext

Emergency contact – Please enter Name and Phone number below:

_____

_____

Dental Insurance

Can be skipped if Self pay

* **Name Of Subscriber:** _____ _____
First Last

* **Subscriber Date of Birth:** _____

* **Patient's relationship with insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other

* **Insurance name:** _____

* **Insurance group number:** _____

* **Insurance ID number:** _____

* **Insurance Authorization:**

☐ By checking this box,
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all the necessary information to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Medical History

Primary physician's full name and phone number of your physician:

_____

* **Please check the box below if you have or used to have any conditions or medication. If you have none of the below, please check this box -** ☐

- ☐ Allergy – Amoxicillin
- ☐ Allergy – Hay Fever
- ☐ Allergy – Sulfa
- ☐ Allergy – Benadryl
- ☐ Allergy – Tylenol
- ☐ Allergy – Codeine
- ☐ Allergy – Oxycodone
- ☐ Allergy – Erythro
- ☐ Allergy – Penicillin
- ☐ Allergy – Other
- ☐ Allergy – Aspirin
- ☐ Allergy – Latex
- ☐ Allergy – Nickle
- ☐ Pre-Med – Clindamycin
- ☐ Pre-Med – Amoxicillin
- ☐ Pre-Med – Other
- ☐ Blood Thinner Medication
- ☐ Rheumatism
- ☐ Sleep Apnea
- ☐ Ulcers
- ☐ Tumors
- ☐ Excessive Bleeding
- ☐ Blood Disease
- ☐ Diabetes
- ☐ Prediabetes
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Stroke
- ☐ Arthritis
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ Keflex (Cefalexin)
- ☐ Anemia
- ☐ Artificial Joints
- ☐ COPD
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Nervous Disorders
- ☐ Hypothyroidism
- ☐ Tuberculosis
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Vertigo
- ☐ Epilepsy
- ☐ Salicylic Acid
- ☐ Adrenal Hyperplasia
- ☐ Mental Disorders
- ☐ Venereal Disease
- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Cancer
- ☐ Radiation Treatment
- ☐ HIV
- ☐ Kidney Disease
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Fainting
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Other

- ☐ Hospitalized (illness or injury)
- ☐ Weight control medication (i.e., fen-phen)
- ☐ Subject to frequent headaches
- ☐ FEMALE: Taking birth control pills
- ☐ Presently being treated for any other illnesses
- ☐ Taking dietary supplements
- ☐ A smoker or smoked previously
- ☐ FEMALE: Pregnant

If any condition or alert selected above needs further clarification, please explain below:

_____

_____

Do you take antibiotic premedication for your dental visits? ☐ Yes ☐ No

List of all medications, supplements, and/or vitamins taken within the last two years:

_____

_____

If you have a preferred pharmacy to send the prescription to, please provide us with their name and address:

_____

_____

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long you have been a patient there:

_____

Date of most recent dental exam: _____ **Date of most recent dental x-rays:** _____

I routinely see my dentist every:

☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

What is your immediate concern?

_____

Personal History. Check all that apply:

☐ I had an unfavorable dental experience.
☐ I had/have braces, orthodontic treatment.
☐ I had any reactions to local anesthetic.
☐ I had trouble getting numb.
☐ I had my teeth removed.
☐ I had bite adjusted.
☐ I had complications from past dental treatment.

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

_____

_____

* ☐ **By checking this box, I acknowledge that the above information is correct to my best knowledge, and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

Notice of Privacy Practices Acknowledgment.

The privacy of your medical/dental information is important to us. We understand that your medical/dental information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical/dental information about you.

Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits, worker's compensation, or similar programs.

We may disclose your medical/dental information to government officials in response to a court or administrative order, subpoena, discovery request, insurance companies, or other lawful process, under certain circumstances.

As required by law, we may disclose your medical/dental information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including child abuse or neglect. We may also disclose information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with food or drug defects or problems. We may disclose your health information if we believe that you may be a victim of neglect, abuse, or other crimes. We may share your medical/dental information if it is necessary to prevent a serious threat to your health/safety or the health/safety of others.

* ☐ **By checking this box, I acknowledge that I have received a copy of the dental practice's Notice of Privacy Practices.**

Dental Practice Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

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

All dental services are charged directly to the patient, and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies and will credit any collections from insurance to the patient's account.

Payment for services is due at the time of treatment, or if billed by this office, payment is due within thirty (30) days of billing.
Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

* ☐ **By checking this box, I acknowledge that I have read and fully understood and agree to the terms of this Financial Policy.**

Consent to Electronic Communications

Our Practice, and our respective contractors on our behalf, may utilize the contact information you have provided to us to send you information including appointment reminders, appointment scheduling and treatment reminders, and promotional messages about other services and products that we may offer.

By providing your contact information, including your email address and cellular phone number below, you request and give express written consent to receive communications through emails, and text messages to your cellular phone provided through the use of an automatic telephone dialing system. You understand that the email communications and text messages you agree to receive may include treatment reminders as well as promotional and telemarketing messages. Emails and text messages are not encrypted (i.e., secure), which means it is possible that they could be accessed or viewed by others. Your consent means you agree to receive unsecure emails and text messages and understand the risks. Message and data rates from your cellular carrier may apply for text messages.

You understand you may revoke your consent at any time, though that revocation will not apply to any text messages or emails made in reliance of this consent before your revocation. You may opt-out of receiving email by UNSUBCRIBING to the email. You may reply [STOP, UNSUBSCRIBE, or CANCEL] to stop receiving text messages on your cellular phone.

Please let us know if you would like us to communicate with you by text message and/or email. Your consent to receive communications by email and text messaging is not required in order to receive treatment or services offered by us, but it may enhance your experience. You further acknowledge that you may not consent on behalf of someone else or provide another person's cellular phone number. You represent that you have legal authority to provide consent.

You have the option of receiving communications from us: (1) by email; (2) by text messaging; (3) by both email and text messaging; OR (4) by neither (i.e., you do not consent to receive communications by email or text messaging).

For text messages, please check one box:

☐ Yes - Please communicate with me by text message. I will notify you right away if my cell phone number changes.

☐ No - Please do not send me (unencrypted) text message.

For email messages, please check one box:

☐ Yes - Please communicate with me by email. I will notify you right away if my email address changes.

☐ No - Please do not send me (unencrypted) email.

* **Signature of patient, parent, or guardian:**

Signature: _____ **Date:** _____

Relationship with patient (if sign on patient behalf): _____