Quality Dental Care

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date: _____

Name: _____
LAST FIRST

I prefer to be called: _____ ☐Male ☐Female

Birthdate: _____ Age: ____ SSN: _____

Home Address: _____

_____
CITY STATE ZIP

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Home #: _____ Cell #: _____

Work #: _____ Ext: _____

E-mail: _____

Employer: _____

Employer Address: _____

How Long There? _____ Occupation: _____

Best time to reach you? _____

Who may we thank for referring you? Please Circle
Mailer Google Facebook Driveby
Commercial Yelp Insurance Co.

OR

Family/Friend (Name) _____

Other: _____

Other family members seen by us: _____

Previous Dentist: _____

Last Visit Date: _____

SPOUSE INFORMATION

Name: _____

Employer: _____

Work #: _____ Ext: _____

Birthdate: _____ Age: ____ SSN: _____

Cell #: _____ Email: _____

_____

RESPONSIBLE PARTY

Person Responsible For Account: _____

Contact Information: (If Different Than Above)

_____

Our goal is to make your visit to our office enjoyable. In order to give you the services you expect and deserve, please let us know what is important to you to help us improve your dental visit.

_____

_____

_____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Policy Holder: _____ Relation: _____

Policy Holder's Birthdate: _____

Policy Holder's SSN: _____

Policy Holder's Employer: _____

Insurance ID: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Policy Holder: _____ Relation: _____

Policy Holder's Birthdate: _____

Policy Holder's SSN: _____

Policy Holder's Employer: _____

Insurance ID: _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Cell #: _____ Other #: _____

MEDICAL HISTORY

Do you have a personal physician? _____

Physician's Name: _____

Phone #: _____

Date of last visit: _____

DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

Are you currently in pain? If so, please explain.

_____

_____

_____

Have you ever had a serious/difficult problem associated with any previous dental work?
If so, please explain.

_____

_____

Do you now or have you ever experienced pain/discomfort in your jaw joint? (TMJ/TMD)

_____

_____

Your current dental health is... Please circle.

Good Fair Poor

Do you like your smile?

☐Yes ☐No

Do your gums bleed?

☐Yes ☐No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? Please circle.

Hard Medium Soft

Have you had orthodontic treatment? _____

Do you clench or grind your teeth day or night?

_____

Do you have an unpleasant odor or taste in your mouth?

_____

Is your mouth sensitive to cold, hot, or pressure?

_____

Does food catch between your teeth? _____

I authorize the dental staff to perform any necessary dental service that I may need during diagnosis and treatment.

I understand 6 month appointments routinely consists of an exam, prophylaxis (cleaning), and a fluoride treatment (for all children under 16 and as recommended by Doctor otherwise). Bitewing x-rays will be taken at least once per year as recommended by Doctor, and a full mouth x-ray will be updated every three years. These are our standards of care to give each patient the best service we can provide. Each employer's policy has different allowances and limitations. Since it is the patient who has the contract with the insurance, it is your responsibility to know your insurance coverage. If you have any questions regarding your treatment, you must ask before treatment's rendered.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contracted agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I consent to your use a disclosure of my protected health information to carry out payment activities in connection with my dental insurance claims.

I understand that all payments at the time of the appointment are estimates only and I am responsible for all charges incurred on my account that are not covered by insurance. I understand that all balances on my account are due in full within 60 days are subject to a 16% APR finance charge and $75.00 collection fee if assigned to our collection agency . **I acknowledge** that I have received access to the office's Notice of Privacy Practices.

I authorize the release of any of my dental information including proposed treatment plans, procedure fees, and dental history to the following individuals: _____

_____

Signature Date Relationship

_____

Signature Date Relationship

Since appointments time are reserved just for the patient scheduled, we require 24 hours notice to change appointments without a charge.