

Insured's Employer Name: _____

Employer Address: _____

Address 1

Address 2

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____

Address 1

Address 2

City

State

Zip Code

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 information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Secondary Dental Insurance

Name of Insured: _____

Last

First

MI

Insured's Birth Date: _____

ID #: _____ Group #: _____

Insured's Address: _____

Address 1

Address 2

City

State

Zip Code

Insured's Employer Name: _____

Employer Address: _____

Address 1

Address 2

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____

Address 1

Address 2

City

State

Zip Code

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 information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other | <input type="checkbox"/> aggrenox |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Allergy - Erythro |
| <input type="checkbox"/> Allergy - Hay Fever | <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Allergy - Penicillin |
| <input type="checkbox"/> Allergy - Sulfa | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Migraines | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Other |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Venereal Disease | | | |

- | | |
|---|--|
| <input type="checkbox"/> Ever been hospitalized (illness or injury) | <input type="checkbox"/> Presently being treated for any other illnesses |
| <input type="checkbox"/> Taking medication for weight control (ie fen-phen) | <input type="checkbox"/> Taking dietary supplements |
| <input type="checkbox"/> Subject to frequent headaches | <input type="checkbox"/> A smoker or smoked previously |
| <input type="checkbox"/> FEMALE: Taking birth control pills | <input type="checkbox"/> FEMALE: Pregnant |

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

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Name of physician and their specialty:

Most recent physical exam and purpose:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

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

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

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 mo. 4 mo. 6 mo. 12 mo. Not routinely

What is your immediate concern?

Personal History, Check all that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Had an unfavorable dental experience | <input type="checkbox"/> Had complications from past dental treatment | <input type="checkbox"/> Had trouble getting numb |
| <input type="checkbox"/> Had any reactions to local anesthetic | <input type="checkbox"/> Had/have braces, orthodontic treatment | <input type="checkbox"/> Had your bite adjusted |
| <input type="checkbox"/> Had any teeth removed | | |

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

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 in cash 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.

Fee estimates for dental care can only be extended for a period of six months from the date of consultation.

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 understand and agree to the terms of this Financial Policy.

Notice of Privacy Practices Acknowledgment.

The privacy of your health information is important to us. Our Notice of Privacy Practices describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge that you received a copy of our Notice of Privacy Practices.

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

Signature of patient, parent, or guardian (responsible party):

Signature _____ Date _____

Name and relationship to patient:

Response Date: _____