

Patient Number _____ A B B- C

Health History & Registration

PATIENT INFORMATION (if Minor)

PATIENT'S NAME Last _____ First _____ Middle Initial _____ Sex: M F BIRTHDATE: _____ AGE: _____

SOC SEC #: _____ If Patient is a Minor, give Parent's or Guardian's Name: _____ TODAY'S DATE: _____

Who May We Thank for Referring You to Our Office? _____

Reason for this Visit: _____

PATIENT INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt. # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt. # _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ E-MAIL _____

PREVIOUS ADDRESS (If less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How Long _____

SOC SEC # _____ BIRTHDATE _____ DRIVERS LICENSE # _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

EMERGENCY CONTACT INFORMATION

NAME _____
LAST FIRST MIDDLE

RELATIONSHIP TO PATIENT _____

HOME PH. _____ CELL PH. _____

WORK PH. _____ E-MAIL _____

REFERRAL SOURCE

Whom may we thank for referring you? :

Family Friend Co-Worker Doctor

Name: _____

Or did you find us on your own:

Yellow Pages Yellow Book Billboard Mail Radio

Insurance Web Sign Magazine _____

Newspaper _____ Other _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name: _____

Insurance Co.: _____ E-MAIL _____

Insurance Co. Address: _____

Insured's Employer: _____

Insured's Soc Sec #: _____ Group #: _____ Local #: _____

PATIENT EMPLOYER INFORMATION

Employer Name _____

Employer Address _____

Employer Phone Number _____

*DENTAL HISTORY	YES	NO	*MEDICAL HISTORY*	YES	NO
HOW LONG SINCE you have seen a dentist?			Do you have any CURRENT HEALTH PROBLEMS?	<input type="checkbox"/>	<input type="checkbox"/>
Last COMPLETE Dental Exam, DATE:			Are you under a PHYSICIAN'S CARE now?	<input type="checkbox"/>	<input type="checkbox"/>
Last FULL MOUTH X-RAYS, DATE (16 small films or panoramic):			For what?		
Are you having PROBLEMS now?	<input type="checkbox"/>	<input type="checkbox"/>	What MEDICATIONS are you currently taking?		
WHAT?			Are you ALLERGIC to any MEDICATIONS? <input type="checkbox"/> No <input type="checkbox"/> Yes _____		
Is your present dental Health POOR?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever taken Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear DENTURES? (Partials or Full?)	<input type="checkbox"/>	<input type="checkbox"/>	Are you PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>
Are you UNHAPPY with your dentures?	<input type="checkbox"/>	<input type="checkbox"/>	Do you use cigars/cigarettes, pipe, or chewing tobacco? (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to know more about PERMANENT REPLACEMENT	<input type="checkbox"/>	<input type="checkbox"/>	PLEASE √ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:		
Are you APPREHENSIVE about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	YES NO YES NO YES NO		
Have you had any PERIODONTAL (GUM) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV Pos. <input type="checkbox"/> <input type="checkbox"/> Fainting <input type="checkbox"/> <input type="checkbox"/> Pacemaker/heart surgery <input type="checkbox"/> <input type="checkbox"/>		
Do your gums BLEED, or feel TENDER or IRRITATED?	<input type="checkbox"/>	<input type="checkbox"/>	Anaphylaxis <input type="checkbox"/> <input type="checkbox"/> Food Allergies <input type="checkbox"/> <input type="checkbox"/> Psychiatric care <input type="checkbox"/> <input type="checkbox"/>		
Are your teeth sensitive to hot, cold sweets pressure?(circle) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia <input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> <input type="checkbox"/> Rapid weight gain/loss <input type="checkbox"/> <input type="checkbox"/>		
Are you unhappy with the APPEARANCE of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis <input type="checkbox"/> <input type="checkbox"/> Headaches <input type="checkbox"/> <input type="checkbox"/> Radiation treatment <input type="checkbox"/> <input type="checkbox"/>		
Are you aware of GRINDING, or CLENCHING your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valves <input type="checkbox"/> <input type="checkbox"/> Heart murmur <input type="checkbox"/> <input type="checkbox"/> Respiratory disease <input type="checkbox"/> <input type="checkbox"/>		
Do you have HEADACHES, EARACHES, or NECK PAINS?	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints <input type="checkbox"/> <input type="checkbox"/> Heart problems (please describe) _____ <input type="checkbox"/> <input type="checkbox"/> Rheumatic <input type="checkbox"/> <input type="checkbox"/>		
Have you worn BRACES on your teeth? (orthodontics) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/> <input type="checkbox"/> Shingles <input type="checkbox"/> <input type="checkbox"/>		
Do you have DISCOLORED teeth that bother you? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Atopic (allergy prone) <input type="checkbox"/> <input type="checkbox"/> Hemophilia <input type="checkbox"/> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> <input type="checkbox"/>		
Would you like your smile to LOOK BETTER or DIFFERENT? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back problems <input type="checkbox"/> <input type="checkbox"/> Herpes <input type="checkbox"/> <input type="checkbox"/> Skin Rash <input type="checkbox"/> <input type="checkbox"/>		
Do you REGULARLY use DENTAL FLOSS? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood disease <input type="checkbox"/> <input type="checkbox"/> Hepatitis <input type="checkbox"/> <input type="checkbox"/> Spina bifida <input type="checkbox"/> <input type="checkbox"/>		
Name of Previous Dentist: _____			Cancer <input type="checkbox"/> <input type="checkbox"/> High blood pressure <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/>		
City: _____ State: _____			Chemical dependency <input type="checkbox"/> <input type="checkbox"/> Jaw pain <input type="checkbox"/> <input type="checkbox"/> Surgical implant <input type="checkbox"/> <input type="checkbox"/>		
How do you feel about your teeth?			Chemotherapy <input type="checkbox"/> <input type="checkbox"/> Kidney disease <input type="checkbox"/> <input type="checkbox"/> Swelling of feet/ankles <input type="checkbox"/> <input type="checkbox"/>		
MEDICAL UPDATE			Circulatory problems <input type="checkbox"/> <input type="checkbox"/> Liver disease <input type="checkbox"/> <input type="checkbox"/> Thyroid disease <input type="checkbox"/> <input type="checkbox"/>		
DATE	PATIENT SIGNATURE	DOCTOR SIGNATURE	Cortisone treatments <input type="checkbox"/> <input type="checkbox"/> Malnutrition <input type="checkbox"/> <input type="checkbox"/> Tobacco habit <input type="checkbox"/> <input type="checkbox"/>		
_____	_____	_____	Cough <input type="checkbox"/> <input type="checkbox"/> Material allergies <input type="checkbox"/> <input type="checkbox"/> Tonsillitis <input type="checkbox"/> <input type="checkbox"/>		
_____	_____	_____	Cough up blood <input type="checkbox"/> <input type="checkbox"/> (latex, wool, metal, chemicals) <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/>		
_____	_____	_____	Diabetes <input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> Ulcer/Colitis <input type="checkbox"/> <input type="checkbox"/>		
_____	_____	_____	Epilepsy <input type="checkbox"/> <input type="checkbox"/> Nervous problems <input type="checkbox"/> <input type="checkbox"/> Venereal disease <input type="checkbox"/> <input type="checkbox"/>		
			Family Physician: _____ Phone _____ Email _____		

Patient Signature: _____

Date: _____

Dentist Signature: _____



FINANCIAL POLICY

Welcome to our family! We share your concern about your financial obligations for dental services in order to provide the highest quality dentistry and customer service possible. We have developed the following financial policy to ensure your financial obligations are clearly understood. Please initial the following:

ALL FEES AND ESTIMATED CO-PAYS (if you have dental insurance) ARE DUE AT THE TIME TREATMENT HAS BEGUN UNLESS PRIOR ARRANGEMENTS ARE MADE BEFORE TREATMENT IS PROVIDED.

You are responsible for all balances the insurance company does not pay within 45 days after billing. Broken Appointments or Canceled appointments without a 24 business hour notice will accrue in a charge of \$50 for every 30 minutes scheduled.

- Interest at the rate of 2% per month will be charged to all accounts past 30 days due and to those accounts which go to the in house collection (due to hiring of extra personnel)
- After 60 days, all accounts past due will be sent to a collection agency (a 25% of your balance collection fee is charged for any outstanding accounts that require the assistance of a collection agency) and will be reported to the Credit Bureau which will affect your credit.

A \$30 fee will be assessed for any bounced check.

PLEASE CHOOSE ONE OF THE PREFERABLE METHODS OF PAYMENT BELOW (initial one):

_____ Courtesy Discount: A 5% courtesy discount* → if payment in full is made at the start of the treatment plan (\$500 or greater). We accept Checks, Money Orders, Visa, Master Card, Debit Cards, and Cash.

_____ Pay Per Appointment: The total fee of the treatment plans divided into payments based on the number of visits for your multivisit treatment such as Root Canals, Crown & Bridgework, Dentures, etc... (2/3 of payment on complete treatment plan must be made before work is sent to the laboratory)

- Pre-authorizations on Credit and Debit Cards

_____ Financing Payment Plan: This office will provide financing through one of the following third party finance offices: (financing based on approved credit only)

- Wells Fargo or American General Financing, Dental Fee Plan, Ortho Fee Plan, Capital One, and Care Credit for up to 60 months or a 12 month NO interest option (see financial coordinator for details)

* This courtesy discount and no interest option does not apply to reduced fee, capitation or HMO plans or other promotional offers.

I understand that I am financially responsible for any and all dental services rendered to me, regardless of my insurance coverage. The above stated payment options are the only authorized options available of which I have selected one. I also understand and accept all the contents of this financial policy.

Patients Name _____

Patients Signature _____

Date: _____

Revised Financial Policy: July 1, 2004

Approved: _____, President