

Welcome New Patients

PATIENT INFORMATION

LAST NAME _____	FIRST NAME _____	MIDDLE INITIAL _____
PREFERRED NAME _____	GENDER <u>Male / Female</u>	STATUS <u>Single / Married / Divorced / Widow(er)</u>
ADDRESS _____		CITY, STATE, ZIP _____
BIRTH DATE _____	AGE _____	SOC. SEC. # _____
TELEPHONE (Home) _____	(Work) _____	(Cell) _____
EMPLOYER _____	E-MAIL _____	
IF FULL TIME STUDENT, SCHOOL NAME _____		
HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____		
PERSON RESPONSIBLE FOR THIS ACCOUNT <u>Patient / Guardian / Father / Mother / Husband / Wife</u>		

FAMILY INFORMATION

<i>HUSBAND -- OR -- FATHER IF PATIENT IS A MINOR</i>	<i>WIFE -- OR -- MOTHER IF PATIENT IS A MINOR</i>
LAST _____ FIRST _____ M _____	LAST _____ FIRST _____ M _____
ADDRESS _____	ADDRESS _____
HOME TELEPHONE _____ WORK TELEPHONE _____	HOME TELEPHONE _____ WORK TELEPHONE _____
BIRTH DATE (MO/DAY/YR) _____ SOC. SEC. # _____	BIRTH DATE (MO/DAY/YR) _____ SOC. SEC. # _____
EMPLOYER _____	EMPLOYER _____
DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____	DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____

METHOD OF PAYMENT

I do not have dental insurance and I agree to pay for any and all treatment the day that services are provided.

I do not have dental insurance and I agree to pay for any and all treatment *prior to* the day that services are provided to receive a 5% discount.

I have dental insurance and would like to have this office file insurance claims for me. I would like to keep a major credit card on file and once my insurance company has paid their portion, the balance is to be paid by the credit card on file. A copy of the insurance payment and a credit card receipt will be mailed to me.

CARD NO: _____ Expires _____

Type of Card: MC / VISA / DISC / AMEX _____

Cardholder Signature

I have dental insurance, but do not have a credit card. I agree to pay for my estimated portion on the day that services are provided.

I have insurance and prefer to pay for my treatment on the day services are provided and file my own insurance claims to receive a 5% discount. I will be provided with a walkout statement from this office to make it easy to file my own claim and receive direct reimbursement.

AUTHORIZATION ALL PATIENTS OR GUARDIANS MUST SIGN

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation, and administering claims for insurance benefits or credit information. I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. **I am aware that I must pay my estimated portion due upfront before I see the doctor unless I have left a valid credit card on file.**

X _____
 PATIENT OR GUARDIAN'S SIGNATURE DATE _____

Insurance Information

PATIENTS WITH DENTAL INSURANCE

IMPORTANT * We are working for you and not the insurance company.

- * We have no control over how well your insurance pays or how well they treat you.
- * There are thousands of combinations of insurance plans and coverages ranging from very poor to fair coverage depending on what your employer purchases for you.
- * We do not base our clinical exam or your treatment plan on what your insurance covers or doesn't cover.

Our policy is as follows:

1. If any payment from an insurance company becomes 60 days past due, then you will be immediately responsible for the entire balance.
2. We will file your pre-treatment estimates at your request, as a service to you. Please be aware that some insurance companies may not honor a pre-treatment estimate or may alter it. In all cases it will delay important dental care.
3. Insurance companies have yearly and sometimes lifetime maximums. It is entirely your responsibility to keep track of this yourself. Sometimes we don't even receive this type of information from the insurance company. You will be responsible for any additional charges incurred. We apologize that we have to have such an involved office policy concerning insurance; however, from past experience we have learned that sometimes there is a big difference in what coverage you think, or have been told, you have and what the companies actually pay for you. The bottom line of our policy is that we will help you in every way, but any difference in what the insurance company pays and the charges for the services we provide for you is due from you.
4. A credit card must be on file for us to accept direct assignment from your insurance company.

Patient Signature _____

Date _____

FOR OFFICE USE ONLY

INSURANCE VERIFICATION

Subscriber _____ ID# _____ Group # _____

Patient _____ DOB _____ Effective Date _____

Eligible Members Family / Self / Spouse / Dependent Benefit Year _____

Insurance Co. _____ Payer ID# _____ Phone No. _____

Send Claims To _____

Individual Max: \$ _____ Family Max: \$ _____ Ortho Max: \$ _____ Ortho %: _____

Individual annual amount used this year: \$ _____ Age Limit _____

Individual DED: \$ _____ P / B / M Family DED: \$ _____ DED Met: \$ _____

Benefit Coverage: Fluoride 01203 _____ x year _____ % Age Limit _____ Date of Last _____

Prev / Diag _____ % _____ % Sealants 01351 _____ x year _____ % Age Limit _____

Basic _____ % Endo _____ % Perio _____ % Oral Surg. _____ %

Major _____ % Crowns B/M _____ % Prosthetics over implant _____ %

Policy Limitations & Waiting Periods:

Coordination of Benefits / Non-Duplication Clause

Missing Tooth Clause Yes / No Replacement Period _____ Waiting Period _____

X-Ray Limit Pano _____ x yrs FMX _____ x yrs BW's _____ x yrs Exams _____ x yrs

Date of Last Pano _____ FMX _____ BW's _____ Propy _____

Fee Schedule: Yes / No Comments: _____

Dental and Medical History

PATIENT NAME _____

BIRTHDAY _____

DENTAL HISTORY

Do you have a specific dental problem? **YES / NO** Please Explain _____
 Do you think you have active decay or gum disease? **YES / NO** _____
 Does food catch between your teeth? **YES / NO** _____
 Do you ever have clicking, popping, or discomfort in the jaw joint or do you grind your teeth? **YES / NO** _____
 Do you smoke or chew tobacco products? **YES / NO** _____
 Do you think you have any sores or growths in your mouth? **YES / NO** _____
 Name of previous dentist: _____ If known, date of last full mouth x-rays (16 small films or panoramic): _____
 Are you interested in a new way to straighten teeth without using traditional braces? **YES / NO**

MEDICAL HISTORY

Are you under a physician's care now? **YES / NO** Why? _____ Who? _____ Phone _____
 Have you ever been hospitalized or had a major operation? **YES / NO** Discuss _____
 Have you ever had serious injury to your head or neck? **YES / NO** Discuss _____
 Are you taking any medications or drugs? **YES / NO** What? _____

Are you on a special diet? **YES / NO** Discuss _____
 Are you allergic to any medications or substances? **YES / NO** Please check all that apply below or fill in if not listed.

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Latex Rubber	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Acrylic	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Codeine	<input type="checkbox"/> Metal	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Women (Please check) Pregnant/trying to get pregnant Nursing Taking oral contraceptives

Please circle below all the conditions you have now or have had in the past.

Heart Trouble/Disease	Bruise Easily	Emphysema	Yellow Jaundice	Cold Sores
Heart Murmur **	Anemia	Tuberculosis	Kidney Problems	Fever Blisters
Irregular Heart Beat	Excessive Bleeding	Cancer	Renal Dialysis	Herpes
Angina / Chest Pain	Sickle Cell Disease	X-Ray Treatments (Radiation)	Thyroid Disease	Stroke
Heart Attack / Failure	Hemophilia (Bleeding Problem)	Chemotherapy	Parathyroid Disease	Convulsions
Congenital Heart Disorder	Leukemia	Stomach/Intestinal Disease	Arthritis/Gout	Epilepsy or Seizures
Mitral Valve Prolapse **	Recent Blood Transfusion	Ulcers	Rheumatism	Fainting or Dizziness
Scarlet Fever	Swelling of Limbs	Recent Weight Loss	Pain in Jaw Joints	Glaucoma
Rheumatic Fever **	Lung Disease	Frequent Diarrhea	Cortisone Medicine	Tumors or Growths
Artificial Heart Valve **	Breathing Problem	Diabetes	Artificial Joint **	Nervousness
Heart Pace Maker **	Shortness of Breath	Excessive Thirst	Venereal Disease	Psychiatric Care
Heart Surgery	Frequent Cough	Hypoglycemia	AIDS	Alzheimer's Disease
High Blood Pressure	Hay Fever	Liver Disease	HIV Positive	Allergies (Medicines)
Low Blood Pressure	Sinus Trouble	Hepatitis A (Infectious)	Genital Herpes	Allergies (Pollen/Dust)
Blood Disease	Asthma	Hepatitis B	Drug Addiction	Hives or Rash
Unexplained Fever	Bloody Sputum	Hepatitis C	Night Sweats	Other _____

To the best of my knowledge, all the preceding answers are correct. If I have any changes to my health status or if my medicines change, I shall inform the dentist and staff without fail.

x

 PATIENT OR GUARDIAN'S SIGNATURE

 DATE