WELCOME!

1. PATIENT INFORMATION

Date:

Last Name _____ First Name _____ MI _____

Sex □ Male □ Female Soc. Sec. # _____ Date of Birth _____ Age _____

Mailing Address _____ City _____ State _____ Zip Code _____

Email _____ Cell Phone _____ Home Phone _____

Employer _____ Work Phone _____ Occupation_____

Emergency Contact _____ Relationship _____ Phone # _____

If under 18, Name of Parent/Guardian _____ Parent/Guardian Soc. Sec. # _____

Parent/Guardian Employer _____ Parent/Guardian Phone_____

Pharmacy Name _____ Pharmacy Address_____

Reason for today's visit _____

How did you hear about us? □ Internet/Online □ Drive By/Walk-In □ Family/Friend □ Insurance □ School Event □ Social □ Media Mailer

2. DENTAL INSURANCE INFORMATION *(Primary Carrier)*

Insurance Co _____ Group # _____

Insurance Co Provider Phone # (back of card) _____

Subscriber/Member ID # _____

Subscriber's Full Name _____

Subscriber's DOB _____

Patient's Relationship to Subscriber _____

3. DENTAL INSURANCE INFORMATION *(Secondary Carrier)*

Insurance Co _____ Group # _____

Insurance Co Provider Phone # (back of card) _____

Subscriber/Member ID # _____

Subscriber's Full Name _____

Subscriber's DOB _____

Patient's Relationship to Subscriber _____

4. FINANCIAL POLICY & COMMUNICATION AUTHORIZATION

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards, or one of the third-party financing options we provide. □ **Please check if you would like more information about financing options.**

If you have insurance:

• We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.

• As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

• We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

• We ask that you pay any deductibles and/or co-payments (estimated costs not covered and mandated by your insurance company) by cash, check, credit card or one of the third-party financing options we provide.

• We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to the dental office. I understand that I am ultimately responsible for payment of all dental services provided to me or my dependents in this office. Payment is due and payable at the time services are rendered unless prior financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. **Please Note:** Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, the patient/guarantor will be responsible for any collection and/or legal charges

I also authorize my dental office to contact me at any telephone number I provide to the practice, including by phone call or text message, for purposes related to my dental care, appointments, billing, account, promotional offers, or other lawful healthcare operations. I understand that information I send to my dental office by text message may not be secure and may carry privacy risks.

_____ _____

Patient/Legal Guardian Signature Date

5. HIPAA DISCLOSURE

I understand that I have certain rights to privacy regarding my health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize the office to use and disclose my protected health and personal information to carry out the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third-party payers (e.g. my insurance company)
- The day-to-day healthcare operations of this practice

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations; the practice is not required to adhere to these requested restrictions. I understand that I may revoke this consent, in writing, at any time. Any use or disclosure that occurred prior to the date I revoke this consent is not affected.

By signing below, I acknowledge that I have received the Notice of Privacy Practices (NPP), digitally and/or in-office. I am also aware that I can review it at any time by scanning the QR code at the front desk or by visiting the practice website. I can also ask for a printed copy at any time.

_____ _____

Patient/Legal Guardian Signature Date

OFFICE USE ONLY:

On _____, the patient declined to sign the acknowledgement of NPP receipt. _____

Date Employee Signature

6. DENTAL HISTORY **Please mark (x) on any of the following conditions that apply to you**

Patient Name (print):

Appearance
- □ Discolored teeth
- □ Flat/worn teeth
- □ Misshaped teeth
- □ Crooked teeth
- □ Crowding
- □ Spaces/missing teeth
- □ Deep bite

Pain/Discomfort
- □ Sensitivity (hot, cold, sweets)
- □ Pressure/pain with chewing
- □ Broken teeth/restorations
- □ Dry mouth
- □ Other: _____

Function
- □ Grinding/clenching
- □ Morning headaches
- □ Jaw joint (TMJ) pain
- □ Jaw joint (TMJ) clicking/popping
- □ Speech impediment
- □ Mouth breathing
- □ Sore muscles (head, neck)
- □ Difficulty opening or closing
- □ Difficulty chewing on either side

Periodontal (Gum) Health
- □ Bleeding, swollen gums
- □ Bad breath
- □ Loose, tipped or shifting teeth
- □ Previous perio/gum disease

Sleep Patterns or Conditions
- □ Sleep Apnea
- □ Snoring

Habits
- □ Thumb sucking
- □ Nail biting
- □ Cheek/lip biting
- □ Chewing on ice/foreign objects

Frequent/Daily Use
- □ Soda/sweet tea
- □ Coffee with creamer/sugar
- □ Sports/energy Drinks
- □ Candy/sweets
- □ High carb diet

Social

Smokeless tobacco use □ Y □ N
Cigarette use □ Y □ N
If yes, _____ packs per day
Vaping Use □ Y □ N
If yes, frequency _____
□ Alcohol frequency _____
□ Drugs frequency _____

Previous Comfort Options
- □ Nitrous Oxide
- □ Oral sedation (pill)
- □ IV sedation

Please share the following dates: Your last dental visit _____ Your last cleaning _____

What is the most important thing to you about your dental visit today? _____

_____

On a scale of 1-10, with 10 being the highest rating: Dental Anxiety 1 2 3 4 5 6 7 8 9 10 Happy with your smile 1 2 3 4 5 6 7 8 9 10

What would you like to change about your smile? □ Color □ Bite □ Chipped Teeth □ Spaces □ Crowding □ Smile Makeover □ Missing Teeth □ Whiter Teeth □ Teeth Sensitive to hot, cold, sweets or pressure □ Other _____

7. MEDICAL HISTORY **Please mark (x) as your response to indicate if you currently have or have had any of the following**

Medical Allergies
- □ Antibiotics *(Penicillin, Amoxicillin, Clindamycin)*
- □ Opiods *(Percocet, Oxydodone, Tylenol 3)*
- □ Latex
- □ Local anesthetics
- □ NSAIDs

Other Allergies/Comments

_____
_____
_____
_____

Cardiovascular
- □ Angina (chest pain)
- □ Heart conditions
- □ Heart surgery
- □ High/Low blood pressure
- □ Pacemaker
- □ Stroke

Respiratory
- □ Asthma
- □ Emphysema/COPD
- □ Respiratory problems
- □ Sinus problems
- □ Sleep apnea
- □ Tuberculosis

Endocrinology
- □ Diabetes
- □ Hepatitis A/B/C
- □ Kidney disease
- □ Liver disease
- □ Thyroid disease

Gastrointestinal
- □ Reflux
- □ Gastrointestinal disease

Hematologic/Lymphatic
- □ Anemia
- □ Blood disorders
- □ Bruise easily
- □ Excessive bleeding

Neurological
- □ Anxiety
- □ Depression
- □ Dizziness/fainting
- □ Drug/alcohol addiction
- □ Seizures
- □ Psychiatric illness

Skeletal
- □ Artifical joint

_____
- □ Arthritis
- □ Osteoporosis
- □ Bone disease
- □ Head/neck/facial injury

Viral Infections
- □ AIDS
- □ HIV positive
- □ HPV
- □ Cold sores

Cancer

Type_____
- □ Chemotherapy
- □ Radiation therapy

Women
- □ Currently pregnant

Due date_____
- □ Nursing

Are you under the care of a physician? If yes, please explain _____

Physician Full Name _____ Phone _____

Have you ever had a serious illness, operation, or hospitalization? If yes, please explain _____

_____

Please indicate if you have had any of these conditions: □ Artificial Heart Valve □ Previous Infective Endocarditis □ Damaged Heart Valves in Heart Transplant □ Unrepaired Cyanotic CHD □ Repaired CHD with Residual Defects

Current medication list _____

Are you currently taking a GLP-1 medication □ Y □ N If yes, how do you take it? □ Injection □ Oral (pill/tablet) □ Other _____

Have you ever in the past, or are you now currently taking any medications for Osteopenia/Osteoporosis or Bone Disease? If yes, please list medications _____

Are you taking any blood thinners? If yes, please list _____

PATIENT DISCLOSURE AND CONSENT

I certify that the information provided above is true and complete to the best of my knowledge. I understand that providing inaccurate or incomplete information may affect my dental care. I agree to notify the office of any changes to my medical history, medications, or health status.

_____ _____ _____
Signature of Patient/Legal Guardian *Print Name* *Date*

_____ _____
Dentist/Hygienist Signature *Date*