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Name: _____ Name you prefer to be called _____ Date ____ / ____ / ____
 Address _____ Daytime Phone (____) ____ - ____
 City _____ State _____ Zip _____ Evening Phone (____) ____ - ____
 SS # _____ - _____ Birthdate ____ / ____ / ____ Sex ____ Other Phone (____) ____ - ____
 Occupation or School (if student) _____ E-mail _____
 Single Married Divorced Widowed Whom may we thank for referring you? _____
 In case of emergency contact: _____ Phone: _____ Relationship _____

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ONLY
 Person responsible for account _____ Phone (____) ____ - ____
 Address _____ City _____ State _____ Zip _____
 Signature _____ Relationship to patient Parent Guardian Other _____

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 Employer _____
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APPOINTMENTS

We recognize the value of your time. Except in emergency cases, you may expect us to be on time, and we appreciate the same courtesy. If you are 15 minutes late for an appointment you are subject to rescheduling. We are able to extend a "no-charge" fee to our patients who give us, at least, 2 business days notice when unable to keep their scheduled appointment. A **charge of \$75** will be made per patient for each appointment that is not kept or not given adequate notice.

Individuals who break 3 appointments without 2 business days notice will be dismissed from our office.

Patients under 18 years old, at all appointments, must be accompanied by an adult who will be responsible for payment and authorization of any required work.

INSURANCE

We are happy to process your insurance forms for you. We ask that you be knowledgeable about the benefits and effective date of your insurance coverage and the coverage for your dependents. Policies will vary.

Your dental insurance is an agreement between you and your insurance company. We are pleased to process your insurance claims with the understanding that you, the patient, are responsible for any expenses not covered by your present carrier. An estimate of your dental charges will be given at your request; however the estimate is NOT a guarantee of your expenses or payment by your insurance company.

OUR FINANCIAL POLICY

In order that you may have a definite understanding regarding the payment policies of our office, they are listed below:

1. Co-payments and outstanding balances are to be paid prior to treatment.
2. Fees listed on estimates are subject to change, unless prepayment has been made.
3. Discounts are not applicable with insurance coverage.
4. There is a \$25 fee for returned checks

OUR GUARANTEE

We are proud to guarantee our work. We give a five year guarantee on crowns and a two year guarantee on fillings received in our office. We extend this guarantee to our patients that complete all recommended treatment and keep all recommended hygiene and restorative appointments.

Thank you for taking the time to read our office policies. If you have any questions, please ask any team member.

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Physician Name _____ Phone _____ Last Physician Visit ____/____/____

Please mark (Y)es or (N)o to each of the following conditions:

- | | | | | | |
|----------------------|---|---------------------|---|---------------------------|---|
| Osteoporosis | <input type="checkbox"/> Y <input type="checkbox"/> N | Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N | Sinus Problems | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Implants/Pins/Screws | <input type="checkbox"/> Y <input type="checkbox"/> N | Seizures | <input type="checkbox"/> Y <input type="checkbox"/> N | Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N | Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N | Allergies | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N | Back Problems | <input type="checkbox"/> Y <input type="checkbox"/> N | Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Rheumatic Fever | <input type="checkbox"/> Y <input type="checkbox"/> N | High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N | Thyroid problems | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Taken Fen-Phen | <input type="checkbox"/> Y <input type="checkbox"/> N | Pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N | Frequent headaches | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Endocarditis | <input type="checkbox"/> Y <input type="checkbox"/> N | Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N | Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N |
| | | Fever Blisters | <input type="checkbox"/> Y <input type="checkbox"/> N | Psychiatric treatment | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N | Iodine Allergy | <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| HIV+/ AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N | Stomach Problems | <input type="checkbox"/> Y <input type="checkbox"/> N | Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Radio/Chemo Therapy | <input type="checkbox"/> Y <input type="checkbox"/> N | Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N | Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> N | Kidney Problems | <input type="checkbox"/> Y <input type="checkbox"/> N | Blood Disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Heart Attack | <input type="checkbox"/> Y <input type="checkbox"/> N | Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N | Hepatitis Type____ | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N | Liver Problems | <input type="checkbox"/> Y <input type="checkbox"/> N | Surgeries/Hospitalization | <input type="checkbox"/> Y <input type="checkbox"/> N |

For Office Use Only

BP: ____/____

PULSE: _____

PREMED: Y N

Notes

Are you allergic to any of the following? Please mark (Y)es or (N)o for each:

- | | | | | | | |
|--------------|---|--------------------|---|---------|---|-------------|
| Penicillin | <input type="checkbox"/> Y <input type="checkbox"/> N | Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N | Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N | Other _____ |
| Tetracycline | <input type="checkbox"/> Y <input type="checkbox"/> N | Latex | <input type="checkbox"/> Y <input type="checkbox"/> N | Jewelry | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N | Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N | Metals | <input type="checkbox"/> Y <input type="checkbox"/> N | |

Are you taking any medications? If so please list:

Medication	Dose	When Taken	Condition	Medication	Dose	When Taken	Condition

Do you smoke? YN # ____ Cig or Pack per day Are you generally healthy? YesNo

Do you have any other disease or condition we should be aware of? YN If yes please explain:

Women Only

Are you taking birth control pills? YN Are you pregnant? YN If Yes, what week? ____ Are you nursing? YN

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Reason for today's Visit: _____ Date of last dental visit: ____/____/____

Former Dentist: _____ Date of Last X-rays: ____/____/____

Please check if you have any of the following problems:

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> PAIN NOW | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Trapping Food | <input type="checkbox"/> Mouth Sores |
| <input type="checkbox"/> Sensitivity to Sweets | <input type="checkbox"/> Gum Disease | <input type="checkbox"/> Pain when Biting | <input type="checkbox"/> Broken Fillings | <input type="checkbox"/> Sensitivity to Cold |
| <input type="checkbox"/> Clicking/Locking Jaw | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Bad Breath | Other: _____ | |

Please mark all you are interested in:

- | | | | |
|--|---------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Home Bleaching | <input type="checkbox"/> Night Guard | <input type="checkbox"/> Veneers | <input type="checkbox"/> Amalgam (silver) Filling Removal |
| <input type="checkbox"/> In-Office Bleaching | <input type="checkbox"/> Sports Guard | <input type="checkbox"/> Bonding | <input type="checkbox"/> Other: _____ |

Authorization and Release

The information on this form is accurate and complete to the best of my knowledge. It is my responsibility to inform the dental office of any changes in my medical status or other information. I will not hold my dentist or any member of his staff responsible for errors or omissions that I have made in the completion of this form. I authorize the administration, with the patient's consent, of medications, and the performance of necessary diagnostic and therapeutic procedures as deemed appropriate by the dentist. I authorize the Doctor choose and employ such assistance as he deems fit. I authorize the dental staff to release information during dental care to third party payers and other health practitioners. I give my permission to the dentist to contact my physician or previous dentist if needed. I understand the use of anesthetic agents embodies a certain risk. I agree to be responsible for payment of all services rendered on my behalf or that of my dependants.

Signature: _____ Date: _____ Relationship to Patient: _____