Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____Date of birth: _____ Sex: _____

Home address: _____ City: _____

State: _____ Zip: _____

Billing address (if different): _____ City: _____

State: _____ Zip: _____

Home phone: _____ Cell: _____ E-mail: _____

Driver's license #: _____ State: _____ SS #:_____

Employer/Occupation: _____ Bus. Phone: _____

Emergency contact name & phone #: _____

Insurance Information

Primary dental insurance: _____ Group #:_____

Secondary dental insurance: _____ Group #:_____

Subscriber's name: _____

Date of birth: _____ SS #: _____

Name of your medical doctor: _____

Date of last visit to medical doctor: _____

Name of previous dentist: _____

Date of last visit to dentist: _____

Referred to us by: _____

DENTAL HEALTH HISTORY Yes or No

Are you nervous about dental treatment? Yes or No	How often do you brush?
Have you had problems with previous dental treatment? Yes or No	How often do you floss?
Do you gag easily? Yes or No	Does your jaw make noise when you open or close your mouth? Yes or No
Does food catch between your teeth? Yes or No	Do you clench or grind your teeth? Yes or No
Do you have difficulty chewing your food? Yes or No	Does it hurt when you chew food or gum? Yes or No
Do you have dry mouth? Yes or No	Do you have headaches in the morning when you first wake up? Yes or No
Do your gums bleed easily? Yes or No	Do you have any pain in your mouth? Yes or No
Do your gums feels swollen or tender? Yes or No	Do you have any pain around your mouth (cheeks, jaws, earaches)? Yes or No
Do you have any sores in or around your mouth? Yes or No	Do you avoid brushing any areas because of pain? Yes or No
Do you have sensitive teeth? Hot? Cold? Sweet? Sour?	Are you unhappy with your smile? Explain

MEDICAL HEALTH HISTORY: Please check any of the following and provide an explanation

Allergies- Seasonal Amoxicillin/Penicillin Latex Codeine Sulfa Other:	History of Surgery or Hospitalization Date:_____ Procedure:	Other:
ADD/ADHD	Epilepsy	Mental or Nervous Disorder
Anemia	Fainting	Pacemaker
Arthritis	Glaucoma	Radiation/Chemotherapy
Artificial Joint or other prosthesis	Head Injury	Respiratory Problems
Asthma	Heart Murmur	Rheumatic
Autism	Hepatitis	Sinus Problems
Bleeding Disorder	High Blood Pressure	Stomach Problems
Blood Disease	HIV/AIDS	Stroke
Cancer	Jaundice	Tumors
Diabetes	Kidney Disease	Ulcers
Type I or II	Liver Disease	Venereal Disease

Up to Date on Immunizations: Yes or No

Please explain any of the above if necessary:

_____

_____

If no medical concerns, please check here: _____

Please list any medications you are currently taking:

_____

_____

Women only:	Pregnant	Taking birth control pills

HIPAA Acknowledgement:

I understand that I have certain rights to privacy regarding my protected 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 you to use and disclose my protected health 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 your practice. I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. 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 health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Name: _____ Date:_____

Financial Policy:

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally respondible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collecting form insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company; those charges are the responsibility of the patient. In consideration for the professional services rendered to me or my dependents by this practice, **I agree to pay the charges for the services at the time of treatment** or within an agreed upon period as decided between me and the practice owner. A service charge of 1.5% per month on any unpaid balance will be charged on all accounts exceeding 60 (sixty) days, unless otherwise agreed upon in writing between me and the practice owner.

Name: _____ Date:_____

Appointment Policy:

We pride ourselves on being able to spend quality time with each and every patient we schedule. We strive to make sure our patients feel welcome and unrushed at their visits. In order to do this, each appointment must start and end on time, and even a small disruption can affect the schedule in a big way. You can help us stay on schedule by keeping your appointment time and arriving 5-10 minutes before, and no less than 15 minutes after. We appreciate a phone call more than 24 hours in advance in case you need to reschedule. We also require your estimated copay be paid to schedule any treatment appointments that may be necessary. If we fail to hear from you before two consecutive no-show appointments, we reserve the right to offer you same-day only appointments. When two of these appointments have been met, you may resume scheduled with the estimated copay paid in advance as described above.

I have read and understand the above policy, and by signing below I agree to comply with it.

Name: _____ Date:_____

Consent for Internet Communications:

I grant my permission to the dental practice to upload and store my patient information to the secured web site for the dental practice. I understand that, for security purposese, the site requires a user ID and password for access and use. I understand the dental practice is not liable for any charges, damages or losses that may be incurred or suffered as a result of an unforeseen web attack. I understand that the dental practice will comply with all laws directly or indirectly applicable that may now or in the future govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance and storage of my information. I agree that the practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of their services.

Name: _____ Date:_____

Consent for treatment:

I consent to the diagnostic procedures and treatment necessary for proper dental care. I understand that I will be presented with a treatment plan and estimated fees prior to treatment beginning. I understand that I will be given time and opportunities to ask any questions I may have. By signing below, I am giving permission for diagnostic dental treatment to be rendered. By signing any presented treatment plans, I am giving consent for that treatment plan to be carried out by the providing dentist at this practice. I also agree that any fees incurred in payment for treatment rendered are my sole responsibility; the practice will help with insurance claims but ultimately, I, the patient, am responsible for any costs incurred.

Name: _____ Date:_____