WELCOME

Thank you for your visit today! We appreciate you trusting us to care for your dental health, and are pleased to welcome you to our practice. To help us serve you better, please take a few moments to fill out the following form as completely as you can. If you have any questions, just ask- we will be glad to help. We look forward to working with you!

PATIENT INFORMATION

TODAY'S DATE_____ HOME PHONE_____

NAME_____CELL PHONE_____ _____

ADDRESS_____WORK PHONE_____

CITY_____STATE_____ZIP CODE_____

E-MAIL ADDRESS_____

BIRTHDATE_____MALE_____FEMALE_____SINGLE _____MARRIED_____OTHER_____

WHOM MAY WE NOTIFY IN CASE OF AN EMERGENCY?

NAME_____PHONE_____

WHOM MAY WE THANK FOR REFERRING YOU?

_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?

_____

INSURANCE INFORMATION

POLICY HOLDERS NAME_____BIRTHDATE_____

ID or SOCIAL SECURITY #_____GROUP#_____

NAME OF EMPLOYER_____

NAME OF INSURANCE CARRIER_____

CLAIMS ADDRESS_____PHONE#_____

CITY_____STATE_____ZIP CODE_____

Do you have a second insurance? _____

DENTAL HISTORY

REASON FOR TODAY'S VISIT_____

PREVIOUS DENTIST_____LAST VISIT_____

HOW OFTEN DO YOU BRUSH? _____HOW OFTEN DO YOU FLOSS? _____

CIRCLE ANY THAT APPLY: BAD BREATH BLEEDING GUMS SENSITIVITY TO HEAT

GRINDING TEETH LOOSE TEETH BROKEN FILLINGS SENSITIVITY TO COLD

PERIODONTAL DISEASE JAW NOISE SORES IN MOUTH SENSITIVITY TO BITE

FOOD COLLECTING BETWEEN TEETH

IS THERE ANYTHING YOU WOULD LIKE TO CHANGE WITH YOUR SMILE? _____

_____

PATIENT NAME: _____ **DOB** _____

Appointments

Your scheduled appointment time is specifically reserved for you. We request 48 business hours of notice should you need to cancel. We are aware that unforeseen events sometimes occur, but after missing your second scheduled appointment without notifying us 48 hours in advance, you may be subject to being charged an additional fee.

Insurance

Our office is committed to helping you maximize your insurance benefits, and as a courtesy to you, we submit claims to your insurance on your behalf. Because insurance policies vary, we can only estimate your coverage but we cannot guarantee coverage due to the complexities of insurance contracts. Your estimated patient portion must be paid at the time of service. We will bill your insurance company for services and allow them 45 days to render payment. After 60 days, you are responsible for the entire balance, paid in full. If you have any questions or concerns, our friendly staff is always available to help.

Financial

Your treatment plan will include a breakdown of all anticipated applicable fees. For the convenience of our patients, we accept cash, checks, Visa, MasterCard, Discover, and American Express. Charges are payable at the time of treatment. If special arrangements are needed, please discuss your situation with our financial coordinator prior to receiving treatment.

AUTHORIZATION

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist insurance benefits payable on treatment rendered. I authorize use of this signature on all insurance submissions.

I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf.

_____DATE_____

Patient Signature (Parent/Guardian if Patient is Under 18 Years of Age)

_____ Relationship to Minor Patient