**Welcome to Our Practice!**

We are committed to providing exceptional dental care to our patients in a compassionate, professional environment. The following information is provided to introduce you to our practice philosophy and policies.

***Appointments***

Appointments are scheduled so we can provide the most efficient care in a relaxed setting. We make every effort to honor time commitments and we appreciate patients extending us the same courtesy. Patients are reminded of their appointments 2-3 days in advance by email, text, or phone. Patients are kindly asked to confirm their appointment at least 48 hours prior to their appointment through the reminder method employed.

***New Patient Appointments***

We reserve 90 minutes for each new adult patient visit and 60 minutes for each new child visit. This allows time for us to listen to patient concerns and to properly diagnose and develop appropriate treatment plans.

***Continuing Care***

Our practice is focused on prevention and maintaining optimum oral health. We recommend comprehensive treatment and continuing care on an appropriate recall schedule.

***Children and Adolescents***

We are happy to start seeing children at the age of three. Parents are welcome to accompany their children in the operatories. We require that parents remain in the office with children under the age of 18 for the entire appointment. Failure to comply may result in the appointment being rescheduled.

***Cancellations and Missed Appointments***

We require 48 hours advance notice of a cancellation. Patients who do not provide 48 hours notice of a cancellation or who do not present for a scheduled appointment may be charged a fee. Patients who fail to present for a second appointment may be dismissed from the practice.

***Payments and Insurance***

 Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they deserve. As a result, we offer several payment options, including cash, check, credit card, and third party financing. For patients with dental insurance, we will file the appropriate claim forms.

**Patient Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: M / F Birth Date: \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Status (circle): Single Married Divorced Child Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you first hear about our office? (circle one):

|  |  |  |  |
| --- | --- | --- | --- |
| Another Patient | Another Dental Office | Brochure | Online Search |
| Facebook | Work | School | Insurance Website |
| Sign –Drive by | Walk in | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

Whom may we thank for referring you to our practice?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person Responsible for Account**

Name of responsible party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient (Circle): Self Spouse Parent Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Information**

What is the best way to communicate with you? Home Phone / Mobile Phone/ Text / Email

In the event of an emergency, whom should we contact? Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information (Primary)**

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Birth Date: \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Co Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information (Secondary)**

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Birth Date: \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Co Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment Information**

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancellations and Missed Appointments**

We require 48 hours advance notice of a cancellation. Patients who do not provide 48 hours notice of a cancellation or who do not present for a scheduled appointment may be charged a fee. Patients who fail to present for a second appointment may be charged a fee or dismissed from the practice. After the first missed appointment, a letter will be mailed reiterating our policy and reminding the patient of the risk of dismissal should another appointment be missed.

**I have read the Cancellation and Missed Appointment Policy. I understand and agree to this Policy.**

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

**1. Women:** Are you pregnant/trying to get pregnant/breast feeding? Yes No

2. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic Penicillin Codeine Other Antibiotic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Latex Acrylic Metals Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax Actonel Boniva For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Aredia Reclast Zometa When did you stop? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4. Please list other medications you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had any of the following?**

Chest Pains Yes No Shortness of Breath Yes No Hives/Skin Rashes Yes No

Heart Failure Yes No Ulcers Yes No Alcoholism Yes No

Heart Disease Yes No Mental Health Issues Yes No Herpes Yes No

Heart Attack Yes No Emphysema Yes No Glaucoma Yes No

Heart Problems Yes No Fainting/Dizziness Yes No Steroid Treatment Yes No

Angina Pectoris Yes No Eating Disorder Yes No Arthritis Yes No

Heart Surgery Yes No Epilepsy/Seizures Yes No Dental Implant Yes No

Liver Disease Yes No Persistent Cough Yes No Dentures/Partials Yes No

Hypertension Yes No Tuberculosis Yes No Birth Defects Yes No

Heart Murmur Yes No Asthma Yes No HIV+, AIDS, ARC Yes No

Rheumatic Fever Yes No Hepatitis A Yes No Hay Fever Yes No

Psychiatric

Treatment Yes No Hepatitis B Yes No Tobacco Products Yes No

Sickle Cell Disease Yes No Hepatits C or D Yes No Bruise Easily Yes No

Sinus Trouble Yes No Pacemaker Yes No Jaundice Yes No

Artificial Joints Yes No Night Sweats Yes No Kidney Trouble Yes No

Thyroid Disease Yes No Stroke Yes No Diabetes Yes No

Anemia Yes No Drug Addiction Yes No Chemotherapy Yes No

Blood Transfusion Yes No Cold Sores Yes No Cancer Yes No

Mitral Valve

Prolapse (MVP) Yes No Radiation Therapy Yes No Transplant Yes No

**Dental History**

1. Date of last dental exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Previous dentist's name / location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Are you having tooth or gum pain at this time? Yes No

4. Do you feel nervous about having dental treatment? Yes No

5. Have you ever had a bad experience in a dental office? Yes No

6. Do your gums bleed when brushing / flossing? Yes No

7. Have you ever seen a periodontist? Yes No

8. Have you ever had a “deep cleaning” (Scaling and Root Planing)? Yes No

9. Is there anything you would like to speak with the Doctor about in private? Yes No

10. Would you be interested in discussing ways to improve your smile? Yes No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11.Do you like the appearance of your teeth? Yes No

12.Do you like the color of your teeth? Yes No

13. Are there any old fillings or dental work that you do not like looking at? Yes No

**Do you have any of the following dental concerns**:

Clicking in jaw joint Yes No Sensitivity to: Hot Cold Sweets Biting

Pain in or around your ears Yes No Swelling Bleeding Gums

Difficulty opening or closing Yes No Bad Taste Bad Breath

Difficulty chewing Yes No Food Catching Tooth Pain

History of trauma to jaw or face Yes No Clenching Grinding

Diagnosis of TMJ/TMD Yes No Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_