WELCOME

PATIENT INFORMATION (CONFIDENTIAL)

NAME____ BIRTHDATE____________ Date_______________
Last Mr. Mrs. Ms First Middle

ADDRESS ______________________________ CITY______________________ STATE __________ ZIP______

DRIVER'S LICENSE____________________ SOCIAL SECURITY#________________________

DAYTIME PHONE___________________ HOME#_____________________ MOBILE#______________________

EMAIL ADDRESS: ____

EMPLOYED BY_______________________________________ WORK PHONE___________________________

Person to Contact in Case of Emergency:

1. Name:________________________________ Relation:____________ Phone:______________________
2. Name:________________________________ Relation:____________ Phone:______________________
3. Name:________________________________ Relation:____________ Phone:______________________

Whom may we thank for referring you? ____

Name of person responsible for this account______________________________ Relationship to Patient______________

Address of responsible party____ Phone________________________

Driver's License____________________________ Social Security#________________ Birthdate__________________

Employer________________________________ Work phone ________________________ Ext______________

OFFICE, CANCELLATION AND FINANCIAL POLICIES

Please initial each statement after reading.

*As a courtesy to you we may accept assignment of insurance after verification of your coverage. We must emphasize that, as your dental provider, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.______

*Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. You are financially responsible for all services not covered by your insurance company.______

*Payment is due upon receipt of billing statement. Patient balance not paid, in full within 30 days of the statement issue date are deemed past due. Past due accounts may be subject to late fees, monthly finance charges and may be referred to a professional collection agency and/or attorney for further collection activity. If this action occurs, you will no longer be able to receive services from any dental providers at Dentalflossophy. _____

*All returned checks are subjected to a $35.00 return check fee. _____

*All appointments that are not cancelled 48 hours prior to appointment time will be subject to a $40.00 "No show" Fee. _____

*All payments, including insurance co-payments and deductibles are due and collected in full at the time of service. _____

*You must provide your most current billing address, all available telephone numbers and any other important contact information.

*It is your responsibility to supply our office with any information changes (insurance, name, address, telephone numbers). _____

I have read and understand this Financial Policy.

____ Date ________________________
Signature of Responsible Party

____
Patient Name Patient Date of birth

MEDICAL HISTORY

PHYSICAN'S NAME____ PHONE_______________________

Physician's address: ____ Date of Last Physical Exam ______________

ARE YOU TAKING ANY MEDICATION (Prescription or Over the counter)? ____________ IF YES, PLEASE LIST EACH ONE: ______________

____

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO ANY OF THE FOLLOWING
Please ✓ any that apply to you:

_____Penicillin _____Tetracycline _____Latex _____ Aspirin _____Dental Anesthetics
_____ Erythromycin _____ Codeine _____Other_______________________________________

ARE YOU TAKING ANY MEDICAION? _________ If yes, please list each one: ______________________________

DO YOU HAVE ANY OF THE FOLLOWING?

_____ Arthritis _____ Stroke _____ Drug Addiction _____Asthma
_____ Heart or Lung Ailments _____Kidney Problem _____ Psychiatric Problems _____Anemia
_____ Heart Attack _____ Rheumatic Fever _____ HIV / AIDS _____Stomach Disorder
_____ Heart Murmur _____ Hepatitis _____ Venereal Disease _____Sinus Problems
_____ Mitral Valve Pro-lapse _____Epilepsy or Seizures _____ Tuberculosis _____Hay Fever
_____ High/Low Blood Pressure _____ Diabetes _____ Malignancies _____Blood Transfusion
_____ Excessive Bleeding _____ Thyroid Problems _____ Radiation Treatment _____Eye Disorders/Glaucoma

Hospitalization: ___________ If yes, please explain: _______________________________________

WOMEN: Are you pregnant? _______If yes, week #:______________ Due Date: ___________ Are you taking birth control pills? ___________

DENTAL HISTORY:

Reason for today's visit: ______________________________ **Date of your last dental:** Exam_________ Cleaning__________ X-ray __________

Name of previous Dentist: _______________________________________ Location: ______________________

DO YOU HAVE ANY OF THE FOLLOWING: (Please ✓ any that apply to you)

_____Pain _____ Gums Bleed _____Sensitivity if yes to what: ___hot _____cold _____pressure _____other__________________

_____ Clench/Grind _____ Jaw problems (TMJ/TMD) _____ Stain what kind? ______________________________

_____Bad Breath _____Other dental concerns: ____

Are you happy with the way your smile looks? _______ If no, what would like to change? ______________________________

What is your regular oral hygiene care? (Example: brush 2 x day) Brush: _______x _______ Floss: _______x _______ Dental Visit: _______x _______

AUTHORIZATION AND RELEASE:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I give my consen for the use of e-mail notifications. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits other wise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____ DATE ______________________
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, have received a copy of this office's Notice of Privacy Practices.

______________________________ ____
Please Print Patient's Name Signature of Patient or Legal Guardian Date

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FOR OFFICE USE ONLY

_____**Individual refused to sign**
_____**Communications barriers prohibited obtaining the acknowledgement**
_____ **An emergency situation prevented us from obtaining acknowledgement**
_____ **Other (Please Specify)** ____