Our Policies

Late Show Policy _____ *(Initial if you have read and understand)*

In order for us to seat our patients on time and adhere to finishing treatment in the amount of time scheduled, we are introducing a Late Show policy. We encourage prompt arrival for all appointments otherwise not all treatment will be able to be performed and if the tardiness continues then the appointment will be rescheduled.

Appointment Policy _____ *(Initial if you have read and understand)*

Effective January 1, 2009, there will be a $35.00 charge enforced to all no show/cancellation/rescheduled appointment without a 24 hour notice. The courtesy of this 24 hour notice allows us to provide appointment opportunities to our other patients, including you. Thank you for your support.

Cell Phone Use

Due to equipment used in the office and the amount of time that the patient is scheduled for, we ask that our patients refrain from using their cell phone and please set the phone to vibrate while in treatment operatory.

Insurance Information _____ *(Initial if you have read and understand)*

We understand that changes can occur in regards to our patient's personal information, especially their insurance. We ask that if there are any changes to your Insurance, please let us know in advance so that we can call the new insurance company and make the appropriate changes. Calling the insurance company to find out details about your coverage information takes valuable time that could interfere or postpone treatment that needs to be performed in your scheduled time. If there are any changes that we are not made aware of in advance, then we will proceed with the scheduled treatment as a cash transaction. The treatment cost will be collected up front and we will file your claim to your Insurance and have your Insurance reimburse you your out-of-pocket cost.

Please understand that the implementation of these new policies is so that we can work together to improve your dental experience here at our office. If you have any questions about any of these policies, please feel free to ask one of our wonderful administrative team members.

_____ _____

Patient Signature **Date**

LAST NAME _____ FIRST NAME _____ DATE _____

DATE OF BIRTH _____ SEX _____

MEDICAL HEALTH HISTORY

GENERAL HEALTH *(Please check):* Excellent ❒ Good ❒ Fair ❒ Poor ❒

PHYSICIAN: _____ DATE OF LAST EXAM: _____

ADDRESS: _____ If exam, for what reason? _____

_____ _____

PHONE: _____ _____

ARE YOU TAKING ANY MEDICATION NOW? Yes ❒ No ❒

If yes, list all medications you are taking and for what purpose. _____

_____

_____

HAVE YOU EVER BEEN PREMEDICATED WITH ANTIBIOTICS FOR DENTAL TREATMENT? Yes ❒ No ❒

IF YES, FOR WHAT REASON?_____

ARE YOU ALLERGIC TO *(Please check):*

Penicillin ❒ Codeine ❒ Antibiotics ❒ ALLERGIC TO ANY OTHER MEDICATIONS?

Local Anesthetics ❒ (such as Novocaine) Aspirin ❒ _____

ARE YOU CURRENTLY TAKING ANY DRUGS OTHER THAN FOR MEDICINAL PURPOSES? IF SO, WHAT? _____

HAVE YOU EVER BEEN HOSPITALIZED OR HAVE HAD SURGERY? If so, give name of hospital, reason and dates.

HOSPITAL: _____ REASON: _____ DATE: _____

HOSPITAL: _____ REASON: _____ DATE: _____

Have you had any medical diagnostic x-rays in the last five years? . . . . . Yes ❒ No ❒

Have you had any dental diagnostic x-rays in the last five years? . . . . . Yes ❒ No ❒

Have you had any blood transfusions? . . . . . Yes ❒ No ❒

Are you currently trying to modify your weight? . . . . . Yes ❒ No ❒

Do you take any medications to help in weight reduction? . . . . . Yes ❒ No ❒

Do you use tobacco products? Yes ❒ No ❒ If yes, type_____ How many per day?___

Do you consume alcohol on a daily basis? . . . . . Yes ❒ No ❒

Is your blood pressure: NORMAL ❒ LOW ❒ HIGH ❒ NOT KNOWN ❒

Have you experienced any recent weight change? . . . . . Yes ❒ No ❒

WOMEN: Are you pregnant? Yes ❒ No ❒ HOW LONG? _____

Do you experience pre-menstrual syndrome? . . . . . Yes ❒ No ❒

Do you wear contact lenses? . . . . . Yes ❒ No ❒

DO YOU PRESENTLY HAVE OR HAD IN PAST? *(Please check)*

- ❒ Thyroid Problems
- ❒ Hormonal Problems
- ❒ Ulcers
- ❒ Tuberculosis or Lung Disease
- ❒ Diabetes
- ❒ Epilepsy or Seizures
- ❒ Anemia
- ❒ Postural Hypotension (Fainting Spells)
- ❒ Hypertension
- ❒ Kidney Problems
- ❒ Chest Pains
- ❒ Heart Disease (and/or Pacemaker/Stint/Shunt/etc.)
- ❒ Stroke
- ❒ Rheumatic Fever
- ❒ Congenital Heart Defects
- ❒ Heart Murmur
- ❒ Mitral Valve Prolapse
- ❒ Joint Replacement (Knee/Hip/etc. with Metal Screws/Plates/etc.)
- ❒ Implants (Type)_____
- ❒ Organ Transplants (Type)_____

(Continued on Back)

DO YOU PRESENTLY HAVE OR HAD IN PAST? *(Please check)*

- ☐ Cancer or Leukemia
- ☐ Psychiatric Problems
- ☐ Clinical Depression
- ☐ Sickle Cell Disease
- ☐ Glaucoma
- ☐ Prosthetic Valves or Joints
- ☐ Bruise Easily
- ☐ Jaundice
- ☐ Asthma or Hay Fever
- ☐ Allergies or Hives
- ☐ Sinus Trouble
- ☐ Arthritis
- ☐ Excessive Urination and/or Thirst
- ☐ Prolonged Bleeding Problems
- ☐ Sexually transmitted diseases: (Gonorrhea, Syphilis, Genital Herpes)
- ☐ Genetic Abnormalities
- ☐ Skin Diseases
- ☐ AIDS/HIV Positive
- ☐ Unexplained Fevers
- ☐ Prolonged Sore Throat
- ☐ Enlarged Lymph Nodes
- ☐ Night Sweats
- ☐ Persistent Diarrhea
- ☐ Bluish-Reddish Lesions
- ☐ Fatigue
- ☐ Persistent Cough

Have you ever been treated for HEPATITIS? If yes, TYPE: _____ DATE: _____ YES ☐ NO ☐

Do you have a history of cold sores, fever blisters or canker sores? ..... YES ☐ NO ☐

Are you being treated with immunosuppressive drugs? ..... YES ☐ NO ☐

DENTAL HEALTH HISTORY

Date of last dental exam_____ Date of last dental cleaning_____

Have you ever had any serious problems associated with previous dental treatment?

YES ☐ NO ☐ If yes, explain_____

How often do you brush your teeth?_____

How often do you floss?_____

Do you routinely use a mouth rinse? YES ☐ NO ☐ HOW OFTEN?_____

Do you experience dry mouth (Xerostomia)? ..... YES ☐ NO ☐

Do your gums feel tender or swollen? ..... YES ☐ NO ☐

Do your gums bleed while brushing and/or flossing? ..... YES ☐ NO ☐

Do you avoid brushing any part of your mouth because of pain or sensitivity? ..... YES ☐ NO ☐

Do you feel twinges of pain when your teeth come in contact with hot, cold, sweet or sour? ..... YES ☐ NO ☐

Are any of your teeth sensitive to air or during chewing? ..... YES ☐ NO ☐

What texture brush do you use? SOFT ☐ MEDIUM ☐ HARD ☐

Do you chew on only one side of your mouth? ..... YES ☐ NO ☐

Does food catch between your teeth? ..... YES ☐ NO ☐

Do you feel your teeth are affecting your health in any way? ..... YES ☐ NO ☐

Have you ever had professional advice in dental home care? ..... YES ☐ NO ☐

Do you clench or grind your teeth while sleeping or during the day? ..... YES ☐ NO ☐

Do your facial muscles ever feel tired? ..... YES ☐ NO ☐

Do you wear full dentures? UPPER ☐ LOWER ☐ Do you wear partial dentures? UPPER ☐ LOWER ☐

Do you have retention problems with your full or partial dentures? ..... YES ☐ NO ☐

Do you gag easily? ..... YES ☐ NO ☐

Are you apprehensive (nervous) about your dental treatment? ..... YES ☐ NO ☐

Have you had: NITROUS OXIDE ☐ MEDICATION PRIOR TO TREATMENT ☐

Please add anything you feel is important:_____

CONSENT

The undersigned hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's dental or oral-facial needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents.

_____

PATIENT'S SIGNATURE DATE

(Or Responsible Party's Signature if patient is under age 18)

REGISTRATION

(CONFIDENTIAL)

DATE _____

PATIENT'S NAME (Last) _____ (First) _____ (Middle) _____

AGE D.O.B. MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐

ADDRESS CITY, STATE ZIP

HOME PHONE CELL PHONE E-MAIL

PATIENT'S EMPLOYER ADDRESS WORK PHONE

SS # / / DRIVER'S LIC # OCCUPATION

SPOUSE'S NAME D.O.B. SS # / /

SPOUSE'S EMPLOYER ADDRESS WORK PHONE

PLEASE FILL OUT
IF THE PATIENT IS A MINOR (UNDER AGE 18) OR FULL-TIME STUDENT

MOTHER'S NAME ADDRESS D.O.B. HOME PHONE

MOTHER'S EMPLOYER ADDRESS WORK PHONE

SS # / / DRIVER'S LIC # OCCUPATION

FATHER'S NAME ADDRESS D.O.B. HOME PHONE

FATHER'S EMPLOYER ADDRESS WORK PHONE

OCCUPATION PRESENT POSITION HOW LONG EMPLOYED SS # / /

STUDENT'S SCHOOL NAME(S) _____

PERSON RESPONSIBLE FOR PAYMENT

NAME _____

ADDRESS _____

D.O.B. _____ HOME PHONE _____ WORK PHONE _____

SS # ____/____/____ DRIVER'S LIC # _____ RELATIONSHIP _____

I WILL PAY FOR DENTAL SERVICES TODAY AS FOLLOWS (CHECK PREFERENCE):

☐ CASH ☐ CHECK ☐ CREDIT CARD

_____

RESPONSIBLE PARTY'S SIGNATURE

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED (PERSON NOT LIVING WITH YOU)

NAME _____ HOME PHONE _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

(Continued on Back)

DENTAL INSURANCE INFORMATION

INSURANCE CO. (PRIMARY) NAME	INSURED	EFFECTIVE DATE
ADDRESS	PHONE NUMBER	GROUP NUMBER
INSURANCE CO. (SECONDARY) NAME	INSURED	EFFECTIVE DATE
ADDRESS	PHONE NUMBER	GROUP NUMBER

ACKNOWLEDGEMENT & AUTHORITY

All professional services rendered are charged to the patient. It is our office policy to bill your insurance carrier as a courtesy to you, although the patient is responsible for all fees regardless of insurance coverage. The range of benefits depends solely on what the employer who purchases the plan wishes to offer employees or members. For example, if your plan states that it will pay 80% of the cost of dental treatment, it means 80% of the fee as determined by the insurance company, and not necessarily the actual fee charged by the dentist. To expedite processing, we ask that you provide complete and accurate insurance information to our Business Office and advise us of any carrier or coverage changes when they occur.

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits to be paid to the undersigned dentist, and I am financially responsible for all non-covered services. I also authorize the doctor to release any medical or health related information required to process my insurance claim.

INSURED, Signature _____ DATE _____