



To whom may we thank for your referral?

What brought you in to see us today?

What is your main concern?

Are you having discomfort at this time? No Yes

How long has it been since you have been to the dentist?

Do you have any fear of dentistry? No If yes , please elaborate. What was your dental experience?

How would you score your own dental health on a scale of 1 to 10 (10 being perfect)?

What would make your health a perfect 10?

What has kept you from doing these things these things before now?

How do you see your mouth in 10-20 years from now?

How important is it that you keep your teeth for a lifetime?

If you could change anything about your smile, what would it be?

Do you ever have bad breath or bad taste in your mouth?

Do your gums bleed during flossing?

Does food wedge between your teeth? No Yes Where?

Are you aware of any swelling or lumps in your mouth? No Yes

Do you ever hear popping or clicking noises when you chew?

Do you get headaches or muscle soreness? No If yes, please describe?

Are you pleased with the color of your smile? No Yes

Have you ever had your teeth straightened? No Yes

Do you have any missing teeth? No Yes

When and how was it lost?

Do you have particular concerns about your dental health or dental treatment that we have not discussed?



Chart #:

FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
 Gender: _____ Family Status: _____
 Social Security #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____
 Email Address: _____
 Address: _____
Street Apartment #

City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____
 Date of last health care exam: _____ What was this exam for? _____
 Have you been hospitalized in the last 5 years? (Please circle) No Yes
 If yes, reason: _____
 Are you currently receiving care? No Yes If yes, nature of care: _____
 Please list all the names and phone numbers of the **physicians** who are currently providing you care:
 1. _____
 2. _____
 3. _____
 4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	H.I.V. Infection/AIDS	No	Yes

Are you required to Pre-Medicate before dental treatment? No Yes

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes

If yes, what is it usually: S /D

Are you allergic or have you had a reaction to:

- a. Local anesthetics No Yes
- b. Penicillin or other antibiotics No Yes
- c. Aspirin No Yes
- d. Codeine, valium or other sedatives..... No Yes
- e. Other

Are you a smoker? No Yes

If so, how much do you smoke per day? _____

Do you snore? No Yes Do you get frequent headaches? No Yes

Please list any medications you are currently taking:

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____

Are you taking Tagamet (Cimetidine)? No Yes If yes, how often? _____

Do you take Antacids? No Yes If yes, how often? _____

Are you taking any herbal supplements/medicines? No Yes If yes, which ones? _____

Diet: Restricted Diet _____

How many meals a day _____

Food Allergies _____

Sugar in your diet: None Slight Moderate High

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: _____

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code Phone

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? Yes No

Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary
Name of Insured: _____ Is insured a patient? Yes No

Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial **arrangements** must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in **their** care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services **performed** without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such 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.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at **the** time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable **value** of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a **waiver** of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further **agree** to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to **telephone** me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and **payment** and agree to their content.

Signature of patient, parent or guardian

Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Date: _____ Relationship to Patient: _____



Financial Policy

Thank you for trusting us to be your dental care provider. We appreciate the opportunity to serve you. We are concerned about the ever-rising cost of dental care and are dedicated to holding down costs to our patients. My staff is committed to your successful treatment and well-being.

Please read the following financial policy and information carefully and sign at the bottom of the page prior to treatment. If you have any questions, please ask Tammy or April for clarification.

1. You are responsible for payment of the services you receive in our office. Please understand that your dental insurance is a contract between **you and your insurance company**. You are ultimately responsible for any unpaid balance.
2. There are hundreds of insurance carriers and plans in place today. They can and do change, often yearly and in some instances more frequently. It is your responsibility to know your plan benefits including co-pay amounts, deductibles and what are covered and non-covered services. We are here to practice dentistry in the best interest of the health of our patients. Often times there is a conflict between what our clinicians need to do to practice good dentistry and what may be covered by your insurance carrier. You will be billed for non-covered benefit services. Common examples of these potentially non-covered services include fluoride treatment, cosmetic treatment, or TMJ treatment. It is your responsibility to know whether your insurance plan covers (pays for) these services or not.
3. A very common tactic of the insurance companies is to tell patients that the clinician's fees are above what they call "usual and customary" even though the insurance companies refuse to disclose what they consider usual and customary fees. Insurance companies then reimburse at a lower dollar amount which often infuriates our patients. Our office has filed our fees and have had all our fees approved by Washington Dental Service (WDS). If your insurance company tells you that the fees charged are above usual and customary, please be assured that this is an arbitrary number chosen by them to limit payments and preserve their profit margin. We **DO NOT** adjust our fees based on insurance companies usual and customary payment schedules.
4. Your co-payment is due at the time of your visit. We accept payment in cash, check, Visa, MasterCard and American Express. We will provide a receipt for all payments. Please retain this receipt for your records.
5. Beginning January 1, 2004, if you choose not to pay your copay at the time of service we will charge a service/late fee of \$25 for each date of service.
6. If you have no insurance coverage you have two options:



- Pay in full at the time of service to take advantage of a 5% discount. We accept cash, check, Visa, Mastercard, or American Express, although if a credit card is used we cannot honor the 5% discount.
 - Take advantage of DFP (Dental Fee Plan), which offers a Flexible Payment Option with low, fixed rates ranging from 5.99% to 12.99% A.P.R. or Interest Free Option if balance is paid within the interest free period. Please let Tammy know if you would like to use this program. The application process is short and simple.
7. If you have insurance coverage, please give your current insurance identification card to Tammy. We will gladly bill your insurance company directly with the appropriate charges and diagnostic codes provided by your Dentist. Please do not ask us to change codes afterwards if your insurance carrier does not pay for your services. We follow strict coding guidelines established by the American Dental Association.

I have read and understand the above financial conditions. I agree to the requirements as stated.

Patient/Parent Guardian _____ Dated: _____