

Date\_\_\_\_\_

Home phone\_\_\_\_\_

**Patient information**

Mobile phone\_\_\_\_\_

Email\_\_\_\_\_

Name\_\_\_\_\_

DL #\_\_\_\_\_ Social Security#\_\_\_\_\_

Address\_\_\_\_\_

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

Sex\_\_\_\_\_ Age\_\_\_\_\_ D.O.B.\_\_\_\_\_ **Single** **Married** **Other**

Patient employed by\_\_\_\_\_ Occupation\_\_\_\_\_

Referred by\_\_\_\_\_

Emergency contact\_\_\_\_\_

**Primary insurance**

Policy holder\_\_\_\_\_ Relation to patient\_\_\_\_\_

D.O.B \_\_\_\_\_ Social Security # \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber employed by \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Address \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber ID \_\_\_\_\_

**Additional Insurance**

Policy holder\_\_\_\_\_ Relation to patient\_\_\_\_\_

D.O.B \_\_\_\_\_ Social Security # \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber employed by \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Address \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber ID \_\_\_\_\_

**Reason for Today's Visit** \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

**Check if you have problems with the following:**

Bad breath\_\_\_ Bleeding gums\_\_\_ Grinding teeth\_\_\_ Hot/ Cold Sensitivity\_\_\_ Loose teeth\_\_\_ broken fillings\_\_\_ Food collection between teeth\_\_\_ Sores or growths in mouth\_\_\_ Periodontal issues\_\_\_ Clicking or popping jaw\_\_\_ Sensitivity to sweets\_\_\_

**Medical history**

Have you had any serious illnesses or operations \_\_\_\_\_  
(Women) Are you pregnant Are you taking birth control pills Y N

**Check if you have any of the following**

Aids\_\_\_ Anemia\_\_\_ Arthritis/Rheumatism\_\_\_ Artificial heart valve\_\_\_ Artificial joints\_\_\_ Asthma\_\_\_ Back problems\_\_\_ Blood disease\_\_\_ Cancer\_\_\_ Chemo\_\_\_ Chemical dependency\_\_\_ Circulatory problems\_\_\_ Cortisone treatment\_\_\_ Cough (persistent)\_\_\_ Cough up blood\_\_\_ Diabetes\_\_\_ Epilepsy\_\_\_ Fainting\_\_\_ Glaucoma\_\_\_ Heart murmur\_\_\_ Heart Problems(describe)\_\_\_ Hemophilia\_\_\_ Hepatitis\_\_\_ High blood pressure\_\_\_ HIV positive\_\_\_ Jaw pain\_\_\_ Kidney disease\_\_\_ Mitral valve prolapse\_\_\_ Nervous problems\_\_\_ Pacemaker\_\_\_ Psychiatric care\_\_\_ Radiation treatment\_\_\_ Respiratory disease\_\_\_ Rheumatic fever Scarlet fever Shortness of breath Skin rash Stroke Swelling feet/ankles  
Thyroid problems\_\_\_ Tobacco habit\_\_\_ Tuberculosis\_\_\_ Ulcer\_\_\_ Venereal disease\_\_\_ Other \_\_\_\_\_

**Allergies / Medications**

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Please list the first and last names of any person(s) we may discuss your appointment, treatment, and or financial obligations with

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**Consent for Internet Communications**

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.

By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

*I was given for review the Notice of Privacy Practices and I authorize this dental practice and its employees, staff, and other personal to access and share medical information with all subsidiaries, business associates (e.g. a billing service) for the purpose of treatment, payment, or other health operations necessary.*

X \_\_\_\_\_

*Interest at the rate of sixteen (16%) percent per annum will be charged on all accounts thirty (30) days past due. In the event your account is referred to our attorney for collection, you will also be liable for attorney's fees incurred in the sum of 33 1/3% of the balance of your account. This sum is in addition to the balance you owe us on your account.*

X \_\_\_\_\_

**PLEASE BE ADVISED**

Due to the high volume of insurance companies that we work with, it is impossible for us to be familiar with them all. Please note that is the patients responsibility to be aware of plan maximums, deductible, co-pays, limitations, waiting periods, etc.

All co-pays and deductibles are due at the time services are rendered.

If you are not prepared, we can reschedule your appointment

for another time. We charge a \$25.00 billing fee per month for all accounts that are 30 days past due.

Please be aware that the time we allow for your appointment is very valuable. When an appointment is scheduled, we expect you to keep it. Our office will charge a \$25.00 per 15 minute fee for all appointments canceled without a 24 hour notice, at the Doctors discretion. We call to confirm 2 days prior to your appointment as a courtesy.

Many insurance companies do not have an allowance for white fillings on posterior (back) teeth. Please keep in mind that a fee per surface will be due upon treatment, by the patient. If the insurance company pays the fee in full, you will be reimbursed.