New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.	Date: / /

Patient Information

First Name:	Middle Name:	Last Name:

Sex:	Age:	Date of Birth (mm/dd/yyyy): / /	Social Security #: - -	Driver's Licence State & #:

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Home Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone: - -	Occupation:

Employer's Address:	City:	State:	ZIP Code:

Send appointment reminders via:

Text Message Email Mail

Please tell us where you heard about us (check all that apply):

Friend or Relative (name): Ad in Mail Saw our Office

Insurance Company Search Engine (Google, etc.)

Other family members treated by us:

Emergency Contact

First Name:	Last Name:	Relationship to Patient:

Home Phone: - -	Work Phone: - -	Cell Phone: - -

Person Responsible for Account

First Name:	Middle Name:	Last Name:	Relationship to Patient:

Date of Birth (mm/dd/yyyy):	Social Security #:	Driver's Licence State & #:	Holder of Dental Insurance for Patient:
/ /	- -		

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Billing Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone:	Occupation:
		- -	

Employer's Address:	City:	State:	ZIP Code:

Insurance Information

Primary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:	Employer:
	/ /		

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to . I permit a copy of this authorization to be used in place of the original. I give , its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):
	/ /

Consent for Treatment

Patient Name:

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

Payment

Payment Method

Notice: Payment is due at the time of service unless alternative arrangements have been made in advance. Please choose a method of payment below.

Payment in Full

Cash				
Check				
Credit Card	Type:	Credit Card Number:	Expiration: /	Card Verification Code: VISA/MC/Discover: 3-digit code printed on back AmEx: 4-digit code printed on front
	Your credit card information is kept on file for outstanding account balances.			

Payment Plans

Start treatment immediately and pay over time with low monthly payments.

CareCredit

Would you like to discuss our office's financial policy? Yes No

Payment Policies

Thank you for taking the time to understand our payment policies. For any questions about fees, financial policies, or your responsibilities, please ask one of our office staff for clarification.

For Patients with Dental Insurance

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

Returned Checks

Personal checks that are returned due to "insufficient funds" are subject to a $35.00 service fee.

Service Charge

Payment is due at each appointment. I agree to pay any outstanding insurance balance within 60 days. If I do not pay the entire new balance within 60 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $2.50 for a minimum balance of $25.00) which is an annual percentage rate of 18% applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account balance or any future accounts. Please be advised that there is a $25.00/hour fee charged for missed or broken appointments without 24 hours notice. To avoid this charge, kindly give us a minimum of 24 hours notice for any appointment cancellation. Feel free to contact us at any time with questions you may have.

X-Ray/Records Release

There is a fee of $25.00 for any release of X-rays and/or records.

Minors

Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Authorization

Patient Name:

I hereby authorize payment directly to of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the above-named patient's dental treatment. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grant the right to to release the patient's dental and/or medical histories and other information about the patient's dental treatment to third-party payers and/or other health professionals.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

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Dental History

Previous Dentist

Last Dental Visit

Last Dental Visit (m/y):

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Today's Visit

Do you have any dental problems, pain, or discomfort at this time? If yes, please describe:

What is the main reason for your visit today?

What would you like to learn more about?

Whitening   Cosmetic Dentistry   Implants   Clear Correct/Invisilign   Sleep Apnea

Other:

Dental Concerns

Check all that apply.

Other Concerns

Smoking/dipping	Orthodontic treatment	Dry mouth
Popping/clicking	Tooth replacement	Wisdom teeth extraction
TMJ	CPAP	Cosmetics
Wisdom teeth	Implants - Tooth #:	Dental phobias
Sleep apnea	Snoring	

Does food tend to get caught between your teeth? If yes, where?

Miscellaneous

Is there anything you'd like to change about your teeth/smile?

Do you have any upcoming event or circumstances (such as weddings, major surgeries, etc.) we should/need to know about? If yes, what and when?

Is there anything else you feel we should know?

Medical History

How is your general health? Good Fair Poor

Are you currently under medical treatment? If yes, what for?

Do you require antibiotic pre-medication for your dental work? If yes, what for?

Physician's Name:	Last Visit: /

Do we have permission to contact your doctor regarding your care? Yes No

Have you ever had:

Check all that apply.

- Arteriosclerosis
- Heart murmur/trouble
- Kidney problems
- Asthma
- Diabetes
- Hepatitis A, B, or C
- Hypertension (high blood pressure)
- Liver problems
- Anemia
- Epilepsy
- Seizures
- Hypotension (low blood pressure)
- Heart attack/stroke
- Heart surgery
- Pacemaker
- Congenital heart defect
- Mitral valve prolapse
- HIV/AIDS
- Blood transfusions
- Sinus problems
- Severe/frequent headaches
- Cancer/chemotherapy
- Radiation treatments
- Psychiatric problems
- Tuberculosis
- Hemophilia
- Abnormal bleeding
- Ulcers/colitis
- Hospitalized for any reason
- Emphysema
- Glaucoma
- Thyroid disease
- Angina
- Gout
- Heart disease
- Osteoporosis
- Recent weight loss
- Sexually transmitted disease
- TMD/TMJ (jaw pain)
- Cough-persistent or bloody
- Swollen neck glands
- Tumor or growth on head/neck
- Alzheimer's disease
- Renal dialysis

Have you ever had an adverse reaction or allergies to any medication or substance?

Check all that apply.

- Aspirin
- Barbiturates (sleeping pills)
- Codeine
- Dental anesthetics
- Iodine
- Latex rubber
- Metals
- Penicillin/antibiotics
- Sulfa drugs

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Are you being/have you ever been treated for cancer of any kind? If yes, please explain:	
Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). Yes No	
Do you smoke or chew tobacco? Yes No	
Have you ever had any excessive bleeding requiring special treatment? Yes No	
When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or feeling tired? Yes No	
Have you been treated in a hospital in the last five years? Yes No	
If female, please mark if you are: Pregnant - If so, please enter your due date or week #:	
Please list all current prescriptions:	
Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly affect your dental treatment:	
All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.	
Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /
For office use: Reviewed by Title Date / /	