Today's Date_____ Name_____
First Middle Last

Address_____
Street City State Zip

Home Telephone_____ Business Telephone_____

E-mail Address_____ Cell Number_____
(if applicable) (if applicable)

Social Security Number_____ Date of Birth_____ Sex M F
Month Day Year

Employer_____ Marital Status_____

Personal Dentist's name_____ Personal Physician's Name_____

All information given on this form is for our records only and will be considered confidential. Please circle answers either **YES** or **NO**. If you are not sure, put a question mark by the question.

Do you have or have you ever had or been treated for any of the following:

Rheumatic Fever	YES	NO	HIV/AIDS	YES	NO
Jaundice	YES	NO	Heart Disease	YES	NO
Diabetes	YES	NO	Heart Murmur	YES	NO
Anemia	YES	NO	Stroke	YES	NO
High Blood Pressure	YES	NO	Epilepsy	YES	NO
Lung/Breathing Disorder	YES	NO	Excess Nervousness	YES	NO
Arthritis	YES	NO			

Are you taking any drugs, medication, pills? YES NO
If you answered yes please list the names of the medications_____
Do you smoke or use smokeless tobacco? If so, how much per day? _____
Are you allergic to, or have you had an unusual reaction to any of the following?

Penicillin	YES	NO	Sulfa Drugs	YES	NO
Aspirin	YES	NO	Sleeping Pills	YES	NO
Codeine	YES	NO	Other (list)	YES	NO

Has your doctor or dentist ever told you that you needed to take antibiotics before dental treatment due to a heart murmur, heart valve or joint replacement, stint, rheumatic fever, or any other condition? YES NO
Have you ever fainted or had the feeling that you were going to "pass out"? YES NO
Please list any significant medical problems not listed above _____
Who referred you to our office? DENTIST FRIEND YELLOW PAGES OTHER_____
Have you ever referred anyone to our office? YES NO If yes, who?_____
Are you having any pain in your mouth right now? YES NO
Have you had any previous periodontal treatment? YES NO If yes, when?_____
Do your gums ever bleed? YES NO If yes, when?_____
Have you noticed any mouth odors or bad tastes? YES NO
Have you noticed any loose teeth? YES NO; Shifting teeth? YES NO; Sensitive teeth YES NO
Are you aware of any grinding or clenching of your teeth at night while you sleep? YES NO

Our practice believes that a good doctor/patient relationship is based on understanding and open communication. We hope that this review of our financial policies will prevent any misunderstanding or disagreements over our payment policies.

Please circle/answer the following:

Are you currently covered by a **DENTAL** Insurance Plan? YES NO

If yes, who is the policy holder? SELF SPOUSE PARENT If spouse or parent, what is their name?_____

Where is the policy holder employed?_____

What is the policy holder's Social Security number?_____

Do you have a **DENTAL** insurance card? YES NO If so, we may need to make a copy of it for our records.

Dental Insurance

As a courtesy to you, we will gladly file your **primary** dental insurance forms for you. If you have a secondary insurance carrier, we ask that you file these claims yourself. We will be happy to assist you in any way in providing information that is needed to process secondary claims.

Dental insurance is a benefit, but can be very different from medical insurance. Many companies rarely pay as much or as quickly as you/we would like. We can only **estimate** what your insurance company will pay. We will help prepare the proper forms and 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 all charges will be paid by the insurance company.

This office does not have information on every individual policy or plan. The only information that we have is the information that you, the patient, provide to us. Therefore, we have no way of knowing whether or not you have met your deductible, met your yearly maximums, have any type of waiting periods for certain procedures, etc.

Please note that this office is not under contract with any insurance company for assignment of benefits—in other words, if your plan is part of a Preferred Provider Organization (PPO) or Provider Network Plan, your benefits may be reduced when seeing an "out of network" or "non-participating" provider.

Patients Without Insurance

Patients without dental insurance will be required to pay in full at the time of service--NO EXCEPTIONS. We gladly accept cash, personal checks, Mastercard or Visa. There will be a $ 25.00 service charge for all returned checks. If needed, we also offer an ***interest free payment plan*** through GE Capital Bank that allows you to make monthly payments on your account.

Financial responsibility/assignment of benefits:

I understand that unless prior arrangements are made, the full balance (less any expected insurance payments) is due and payable at the time of treatment. If I have insurance, I agree to pay any charges not paid by the insurance company after **60** days from the date of service.

Any emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time of service.

I understand and agree to fully comply with the financial policies stated above.

_____

Signature Date

Because of the delicate nature of treatment rendered in our office, please turn off your cellular/Nextel phone while in our office. If you must make a call, please step out into the hallway. Thank you for your consideration of others.