



## New Patient Paperwork

---

**NAME:**

Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ Nickname: \_\_\_\_\_

**ADDRESS:**

Street: \_\_\_\_\_

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

DOB: \_\_\_\_\_  Male  Female SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Mobile: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ If applicable, Spouse's Name: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

How would you like to receive reminders? (Please circle): Phone call, Email, Text

Employer: \_\_\_\_\_ May we contact you at work? YES, NO

How did you hear about us? \_\_\_\_\_

## DENTAL INSURANCE

**Primary Dental Carrier**

Subscriber Name: \_\_\_\_\_ SSN# : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Group #: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

**Secondary Dental Carrier**

Subscriber Name: \_\_\_\_\_ SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Group #: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

If patient is under 18: \_\_\_\_\_ Relation to patient: \_\_\_\_\_



## HEALTH HISTORY

Are you currently under care of a physician for a health issue? \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last physical: \_\_\_\_\_ How do you assess your current health? Good Fair Poor

Check the box to indicate if you have had any of the following condition:

Acid Reflux	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Venereal Diseases	<input type="checkbox"/>
AIDS/HIV	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Hepatitis Type_____	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>
Arthritis, Rheumatism	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Dry Mouth	<input type="checkbox"/>
Artificial Heart Valves	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Jaw Popping	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	Limited Opening	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Clenching	<input type="checkbox"/>
(Hemophilia, Sickle cell)		Pacemaker	<input type="checkbox"/>	Grinding	<input type="checkbox"/>
Breathing problems	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	Facial Pain/Numb	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	Neck Ache	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Bell's Palsy	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>
Clenching	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Dental Anxiety	<input type="checkbox"/>
Congested Ears	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>		
Controlled substance		Sleep Apnea	<input type="checkbox"/>	ALLERGIES	
use	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>
Cough, frequent	<input type="checkbox"/>	Swollen Feet/Ankles	<input type="checkbox"/>	Codeine	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Swollen Neck Glands	<input type="checkbox"/>	Dental Anesthetics	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	Latex	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	Metals	<input type="checkbox"/>
Fainting or Dizziness	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	Tumor or growths	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>
Head/Neck injury	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	Not listed: _____	

Are you currently taking prescription medications? If yes, please list below (name and purpose. Attach additional papers if needed): \_\_\_\_\_

WOMEN: Are you pregnant? YES, NO (if yes, expected delivery date: \_\_\_\_\_)

Are you breastfeeding? YES, NO Are you taking birth control pills? YES, NO

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## DENTAL HISTORY

Previous Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Have you had a less than positive experience? YES, NO  
If Yes, please explain: \_\_\_\_\_

How do you assess your current dental health? (Please circle): Good Fair Poor

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

What other dental aids do you use? Electric toothbrush, Waterpik, Soft-picks

### Please check any that apply:

- Bad breath/taste in your mouth
- Bleeding, swollen gums
- Broken tooth or fillings
- Clicking, popping in jaw
- Grinding or clenching
- Headache, ear aches, neck pain
- Jaw joint pain
- Loose, tipped, shifting teeth
- Mouth ulcers or cold sores
- Sensitivity (hot, cold, sweet)
- Tooth pain or discomfort

### On a scale of 1-10, (10 being the highest):

How important is your dental health?

1 2 3 4 5 6 7 8 9 10

How would you rate your dental health?

1 2 3 4 5 6 7 8 9 10

Importance of my overall health?

1 2 3 4 5 6 7 8 9 10

Importance of preventive care to me?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your visit today? \_\_\_\_\_

What is the most important thing to you about your smile and dental health?  
\_\_\_\_\_

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

Have you been seen by an Orthodontist, had your bite adjusted, or treated for TMJ?  
\_\_\_\_\_

If you could whiten your teeth for a cost anyone could afford, would you do it? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## OFFICE POLICY

### NO SHOW AND CANCELLATION

In order to continue providing excellent quality, yet affordable dental services, it is important for our patients to understand that appointments are reserved for you in advance; please make effort to keep your appointments. Please notify us within 48 hours if you need to cancel your appointment. **In the event of a No Show or Cancellation without 48 hours notice, you will be required to pay a \$50 Reschedule Fee before being placed back on the schedule,** \$25 of which can be used for future services.

A \$250 deposit will be required to reserve an appointment for your surgery date. This fee will be applied to dental work that is scheduled to be done.

### PATIENTS WITH DENTAL INSURANCE

It is your responsibility to provide our office with your dental plan and to let us know of any changes at your appointment. We will continue to try and help you understand your policy but please be aware that there are thousands of different policies and we do not know all of the limitations for all of the plans out there. If for any reason your insurance company does not pay for a procedure, the balance is your responsibility to pay in full upon receipt of the statement.

### I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCUR:

- The treatment goes over my yearly maximum.
- Any treatment that is denied by my insurance company.
- I am not eligible for insurance.
- I prevent or delay by not complying with requests for insurance forms or signatures.
- I do not complete my treatment and it results in non-payment by the insurance company.
- Lab and equipment costs that are incurred due to a missed appointment.
- I received my insurance check and do not send it to the office.

By signing this, I have read and understand the above policy.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## CONSENT FOR TREATMENT

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

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

I agree to the use of anesthetics, sedatives and other medication 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 give consent to the doctor's or designated staff to use and disclosure of any oral written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and healthcare operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protections of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## HIPAA RELEASE OF INFORMATION

I, \_\_\_\_\_, authorized the release of information including the diagnosis records; examination rendered to me and claims information. This information may be release to:

- Spouse \_\_\_\_\_
- Children \_\_\_\_\_
- Other \_\_\_\_\_
- Information is not to be released to anyone

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_