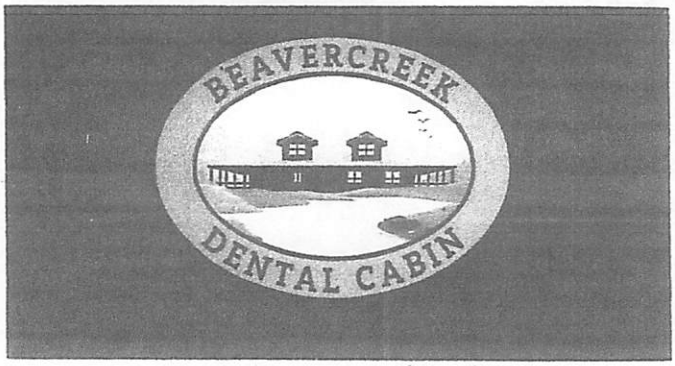


Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

I prefer to be contacted by

☐ Cell Phone ☐ Text ☐ Email ☐ Home Phone

☐ Leave a message

Whom may we thank for referring you to our practice?

_____

In an emergency, who should be notified? Please enter name, phone number and relationship below

_____

Patient Name: _____ _____ _____ _____

Last First MI Preferred Name

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

☐ *Pre-Med	☐ Allergies	☐ Allergy - Aspirin	☐ Allergy - Codeine
☐ Allergy - Erythro	☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin
☐ Allergy - Seasonal	☐ Allergy - Sulfa	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Blood Disease	☐ Cancer
☐ Diabetes	☐ Drug / Alcohol Abuse	☐ Epilepsy	☐ Excessive Bleeding
☐ Fainting / Dizziness	☐ Glaucoma	☐ Head Injuries	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure	☐ HIV / AIDS
☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders	☐ Nervous Disorders
☐ Osteoporosis	☐ Other	☐ Pacemaker	☐ Radiation Treatment
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism	☐ Sinus Problems
☐ Stomach Prob/Ulcers	☐ Stroke	☐ Tuberculosis	

☐ Recent Hospitalization (illness or injury)	☐ Subject to frequent headaches or migraines
☐ Presently being treated for any other illness	☐ Tobacco Use
☐ Pregnant/Planning Pregnancy	☐ Nursing
☐ Taking birth control	

If any conditions or alerts selected above needs further clarification, please describe below

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Name of physician and date of last physical exam

List all medications (prescription and non-prescription), including regular dosages of aspirin.

Please list any allergies and/or allergies to medications.

* ☐ 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.

Name of patient, parent, or guardian completing this form:

*

Relationship to patient:

*

Dental Information

How would you rate the condition of your mouth?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

New Patients: Previous Dentist Name and Phone Number

Approximate date of most recent dental exam and/or dental x-rays

I routinely see a dentist every

◯ 3 mos ◯ 4 mos ◯ 6 mos ◯ 12 mos ◯ Not routinely

What is your immediate concern about your dental health?

Is there anything about the appearance of your smile that you would like to change?

Check all that apply

- ☐ Had any reactions to local anesthetic
- ☐ Had trouble getting numb
- ☐ Sensitive to hot, cold, biting, sweets
- ☐ Food gets trapped between any teeth
- ☐ Clenching or grinding of teeth
- ☐ Experienced gum recession
- ☐ Had complications from past dental treatment
- ☐ Experiences dry mouth
- ☐ Avoid brushing any part of mouth
- ☐ Whitened or bleached your teeth
- ☐ Currently or previously wore a bite appliance

If any of the checked boxes need further explanation, please describe:

Employer Name

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

Employer Name: _____ Phone: _____

Address: _____ _____

_____ _____ _____

City State Zip Code

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ _____ _____ _____

Last First MI Preferred Name

Title: _____ Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Mr/Ms/Mrs/etc

Birth Date: _____ SS #: _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

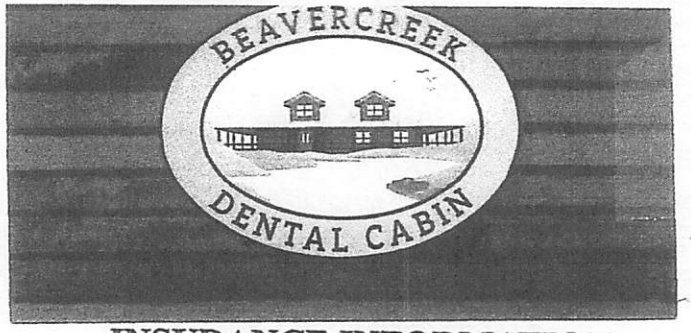
Phone: _____ _____ _____ _____ _____ _____

Home Work Ext Mobile Fax Other

Address: _____ _____

_____ _____ _____

City State Zip Code



INSURANCE INFORMATION

Primary Policy Holder Full Name: _____
Policy Holder Date of Birth: _____ SSN/ID#: _____
Relationship to Patient: _____
Policy Holder Employer: _____
Ins. Company Name: _____
Ins. Company Full Address: _____
_____
Ins. Company Phone #: _____ Group #: _____

* Please sign and date the following:
I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist (dental practice) has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
_____ Date _____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. _____ Date _____

Secondary Policy Holder Full Name: _____
Policy Holder Date of Birth: _____ SSN/ID#: _____
Relationship to Patien _____
Policy Holder Employer: _____
Ins. Company Name: _____
Ins. Company Full Address: _____
_____
Ins. Company Phone #: _____ Group #: _____

* Please sign and date the following:
I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist (dental practice) has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
_____ Date _____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign the Acknowledgment

I, _____ have received a copy of this offices Notice of Privacy Practices.
Signature: _____ Date: _____

Consent for Communication

How would you like us to communicate with you? Our dental office sends appointment reminders, information about treatment, payment and insurance, and other communications. Please tell us how you would like us to communicate with you.

Your name: _____ Today's Date: _____

Contact me by U.S. Mail at the following address:

_____

_____

Contact me by email at the following email address:

_____

_____

For Phone and Text Communications:

Cell Phone Number: _____

Home Phone Number: _____

Work Phone Number: _____

By signing this form, I consent to the following: The dental practice may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance,

Signature: _____ Date: _____

Please call the dental office right away if you get a new telephone number!

Consent for Services and Financial Policy

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. In order to achieve these goals we require your assistance in understanding our payment policy. Your payment in full is due at the time of service or financing. For insured patients, as a courtesy to you we will accept payment directly from your insurance company. We require that your deductible which is determined by your individual insurance plan must be met at the time of service along with any co-pays or non-covered services. All deductibles and co-pays are expected at the time of service. We offer Care Credit financing with 6-12 months same as cash depending upon the amount of treatment. Credit approval is required. Please be aware that any parent bringing a child to the practice is legally responsible for payment of all services rendered regardless of any type or decree. We are not a party to any type of custody agreement which may include expenses to be covered by the other party. It is your responsibility to make payment at the time of service. You understand that we may contact you via phone and mail regarding any past due balance that was not covered by your particular plan. If there is a balance on your account after insurance has settled their part we will expect payment from you within 21 days.

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

HIPAA Acknowledgement

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.

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**