Patient Information

Name: _____
Last First Middle

E-Mail Address: _____ Gender: Male_____Female_____

Cell Phone: (____)_____ Home Phone: (____)_____ Work Phone: (____)_____

Home Address:_____
Street City State Zip

Date of Birth: ___/___/_____ Social Security Number: _____-____-_____ Driver's License or ID Number:_____
MM / DD / YYYY

Responsible Party Information (If Patient is a Dependent)

Name: _____
Last First Middle

Relationship to Patient: _____ E-Mail Address: _____

Cell Phone: (____)_____ Home Phone: (____)_____ Work Phone: (____)_____

Home Address:_____
Street City State Zip

Date of Birth: ___/___/_____ Social Security Number: _____-____-_____ Driver's License or ID Number:_____
MM / DD / YYYY

Dental Insurance Information (Please Provide a Copy of Your Card)

Name of Primary Policy Holder: _____
Last First Middle

Primary Policy Holder's Date of Birth: ___/___/_____ Primary Policy Holder's SS/ Member ID Number: _____-____-_____
MM / DD / YYYY

Primary Policy Holder's Employer:_____Rank:_____

Insurance Company Name:_____ Group Number:_____ Insurance Company Phone: (____)_____

Insurance Company Address:_____
Street City State Zip

Emergency Contact Information

Local Friend or Relative not Living With You: _____ Emergency Contact Phone: (____)_____

Emergency Contact Address:_____
Street City State Zip

Getting to Know You

Why did you select our office? _____ Whom May we thank for referring you?_____

Is another member of your family already a patient with our practice? _____

When was your last dental visit? _____

When was the last time you had complete dental x-rays taken? _____ Have you ever had any teeth removed? _____

How long have these teeth been missing? _____

How Have these teeth been replaced? ❑ Bridge ❑ Partial ❑ Denture ❑ Implants ❑They have not been replaced

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

_____

SIGNATURE OF RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT** **DATE**

HEALTH HISTORY

Name: _____ Date: _____

Birth Date _____ Height _____ Weight _____ Age _____ Gender: ☐ M ☐ F

Please list all medical problems you are currently being treated for: _____

_____

_____

_____

Please list all of your previous surgeries: _____

_____

_____

_____

Please list any drug, food or latex allergies: _____

_____

_____

_____

Please list your current medications: including aspirin or any other over the counter medications: _____

_____

_____

_____

DO YOU HAVE, OR HAVE YOU EVER HAD….

☐Yes ☐No Chest pain
☐Yes ☐No Heart attack
☐Yes ☐No Irregular heart beat
☐Yes ☐No Pacemaker/defibrillator
☐Yes ☐No Heart murmur
☐Yes ☐No Angioplasty/bypass
☐Yes ☐No High blood pressure
☐Yes ☐No Heart valve replacement
☐Yes ☐No Asthma
☐Yes ☐No Shortness of breath
☐Yes ☐No Emphysema/COPD
☐Yes ☐No Sleep apnea

☐Yes ☐No Tuberculosis
☐Yes ☐No Tobacco use
☐Yes ☐No Diabetes
☐Yes ☐No Liver disease
☐Yes ☐No Kidney disease
☐Yes ☐No Thyroid disease
☐Yes ☐No Rheumatic fever
☐Yes ☐No Immune system problems
☐Yes ☐No Hepatitis/jaundice
☐Yes ☐No Cancer
☐Yes ☐No Chemotherapy
☐Yes ☐No Radiation therapy

☐Yes ☐No Bleeding/blood clot problems
☐Yes ☐No Anesthetic problems
☐Yes ☐No Epilepsy/seizures
☐Yes ☐No Glaucoma/eye problems
☐Yes ☐No Ulcers/gastric reflux
☐Yes ☐No History of alcohol or drug abuse
☐Yes ☐No Currently pregnant/nursing
☐Yes ☐No Hip/knee/joint replacement
☐Yes ☐No Blood thinners
☐Yes ☐No Bone density medication
☐Yes ☐No Require antibiotics prior to surgery

DENTAL HISTORY (PLEASE CHECK ALL THAT APPLY):

☐ Routine care only ☐ Orthodontics ☐ Jaw/tooth trauma ☐ TMJ problems ☐ Jaw surgery
☐ Gum disease ☐ Cancer ☐ Mouth sores ☐ Dental implants ☐ Dentures

Please list anything else about your medical or dental history we should know: _____

_____

_____

_____ _____

Signature-Patient/Guardian Dr's initials

UPDATED:_____ **DATE:** _____

Our goal is to make your experience in our office exactly how you want it to be. Please take a few moments and complete this profile so we can be of service to you as comfortable as possible.

1. Please rate the following statements regarding what is most important to you in dental care so we can best serve you: (#1 being the most important)
   ____Long-Term Preventative Care…I have healthy teeth and want to keep them that way.
   ____Creating a Comprehensive Overall Dental Care Plan…I want to Invest in my Teeth and Appearance
   ____Dental Care is budget driven. I will have to plan financially for any treatment beyond my immediate needs.
   ____ Other Goals: _____
2. Please circle how important is it for you to keep your teeth for a lifetime? (10 being very important)
   1 2 3 4 5 6 7 8 9 10

3. Are you concerned about: (please circle yes or no)

Replacing missing teeth	Yes	No	Straightness of your teeth or bite	Yes	No
Eliminating any cavities	Yes	No	Snoring at night	Yes	No
Gum disease	Yes	No	Color of your teeth	Yes	No
Bad breath	Yes	No	Appearance of your smile	Yes	No

4. Are you or anyone in your family interested in a **complimentary** orthodontic (Braces or Invisalign) consultation with our Orthodontist? Yes No

We know dental care can be very stressful for most people. Please share your concerns and past experiences to help guide us in serving you and your family more effectively.

5. Please circle the level of fear you have regarding dental treatment for yourself. (10 being the most fearful, 1 being the least amount of fear)
   1 2 3 4 5 6 7 8 9 10

6. When we review your treatment plan with you, would you like to know (please check one):
   ____I am a big picture type person, I prefer to review the plan looking at all the things that need to be done.
   ___I am a detail oriented person, I prefer to approach each treatment step along the way
7. Please briefly describe any bad dental experiences you have had:
   _____
   _____
   _____

DENTAL INSURANCE POLICY

Dental Studio proudly accepts most dental insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable estimate of patient co-payments and insurance contributions. This estimate is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance exclusions. **This estimate is not a guarantee of insurance payment**. **All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted.** We provide treatment estimates as a courtesy in order to minimize the total out-of-pocket cost due by patient. **All estimated patient co-payments are due on or before time of service.**

Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.

----------PATIENT ACKNOWLEDGMENT AND AUTHORIZATION----------

I understand and agree to the Dental Insurance Policy stated above. I authorize all my insurance companies to make payment directly to Dental Studio. This assignment will remain in effect unless revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature: _____ Date: _____

APPOINTMENT DEPOSIT REQUIREMENT

Dental Studio requires a minimum $50.00 deposit for all appointments requiring 90 minutes or more of estimated chair-time and for all appointments with a total treatment cost of $300.00 or more. The deposit operates as a credit on the patient account towards the total patient portion due on or before time of service. Dental Studio requires this deposit because our providers and dental assistants reserve the appointment time specifically for you at the exclusion of other patients. **The deposit requirement is subject our Cancellation Policy.**

The deposit requirement is reserved only for those patients choosing not to pre-pay for their services in full when scheduling the appointment.

I understand and agree.

Signature: _____ Date: _____

CANCELLATION POLICY

Dental Studio makes an effort to see patients on time in order to give patients they care they deserve. Therefore, we ask that you **please give 48 hours notice if you are unable to keep your scheduled appointment**. **We reserve the right to charge a cancellation fee of $50.00 in the event of two (2) or more missed appointments lacking proper notice.** We will make exceptions in the event of reasonable emergencies.

I understand and agree.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICES

I, _____, have had the opportunity to review Dental Studio's Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature: _____ Date: _____