Patient Information

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

Date of Birth:_____ SSN: _____ Family Status: _____ Driver's License #: _____
Issue State: _____

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

Mailing Address: _____
Street Apartment #

_____ E-Mail: _____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Seasonal Allergies
- ☐ Autism
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valve Replacement
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ STD
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco Smoker (past or present)
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ **Codeine Allergy**
- ☐ **Latex Allergy**
- ☐ **Metal Allergy**
- ☐ **Penicillin Allergy**

OTHER :

- ☐ _____
- ☐ _____

Please list all prescriptions and/or over the counter medications you are currently taking:

_____

_____

Pharmacy Name: _____ **Pharmacy Number:** (_____) _____-_____

- **Are you taking any type of blood thinners?** ☐ Yes ☐ No
  If yes, please list medicine name: _____
- **Have you ever had any complications following dental treatment?** ☐ Yes ☐ No
  If yes, please explain:_____
- **Have you been admitted to a hospital or needed emergency care during the past two years?** ☐ Yes ☐ No
  If yes, please explain: _____
- **Are you now under the care of a physician?** ☐ Yes ☐ No
  If yes, please explain: _____
- **Name of Physician:** _____ Phone: _____
- **Do you have any health problems that need further clarification**? ☐ YES ☐ NO
  If yes, please explain: _____
- **EMERGENCY CONTACT:** _____ **Phone:** _____
  RELATIONSHIP: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient (friend) ☐ Another patient (relative)

☐ Internet ☐ Insurance ☐ Newspaper ☐ Postcard ☐ Other _____

Name of person or office referring you to our practice: _____

HIPAA

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Please print name

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

I give you permission to share my personal information with my Dental Insurance Company and the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please take a few moments to answer the following questions so that we can address all of your questions and concerns.

1. Are you interested in whitening your teeth?	YES	NO	UNSURE
2. Are you interested in straightening your teeth?	YES	NO	UNSURE
3. Would you like to change the appearance of your smile with veneers?	YES	NO	UNSURE
4. Would you be interested in easing TMJ pain with Botox injections?	YES	NO	UNSURE
5. Would you like to learn more about replacing missing teeth?	YES	NO	UNSURE

Other: _____

_____

_____

_____

Dental Warranty

Protect your smile

We Stand Behind What We Do. Peace of Mind Limited Dental Warranty

Patient Name: _____

We are proud of our dental services and what they do for our patients. Our goal is not to overly correct your dental problems, but have the work we do last for many years into the future, to save you time and to save you from unnecessary expenses, and in addition, show you how to prevent dental disease in the future. The long term success of our dentistry is directly dependent on: How well you care for your teeth at home, eating a sensible diet and adhering to the schedule we set for you for the frequency of your professional examinations, cleaning and fluoride treatments. The products we recommend for you and the frequency of professional continuing care visits depends on your individual situation.

With these thoughts in mind, we are pleased to offer the following limited dental warranty:

Sealants

If our dental sealants are in need of repair with normal use during a period of two (2) years from the date of initial placement, we will replace or repair them at no additional charge.

Composite *(tooth colored)* Fillings

If a composite filling is the *recommended* treatment of choice, we will replace or repair it in the event of a failure for a period of two (2) years. Composite restorations done as a *compromised* form of treatment (instead of a crown, inlay, onlay or veneer) are not covered under this warranty. If the restoration itself (NOT THE REMAINING TOOTH STRUCTURE) breaks or fractures within two (2) years and requires a crown, or onlay, we will credit any out of pocket expense for the filling towards the additional service.

Root Canals

Root Canals are 95% successful but not 100%. If you have a root canal and the recommended final restoration for your tooth (post and core and a full coverage crown) and your root canal fails within two (2) years we will credit your account your total out of pocket expenses of the root canal toward replacement bridge or implant crown.

Crowns, Bridges, Inlays, Onlays and Porcelain Veneers

We have learned that despite our best efforts, any of these tooth restorations can fail for a variety of reasons that include new decay, breakage from excessive grinding of one's teeth, or simply biting down on a hard object such as a fork, bone, or nut. In fairness to both patient and doctor we will warranty these lab created restorations on a sliding scale of replacement cost in the unlikely event that you should require replacement in the first five (5) years. The percentages reflect ***your portion*** of the current fees at the time replacement is needed.

First year	0%	Fourth year	60%
Second year	0%	Fifth year	70%
Third year	0%	Sixth+ year	100%

Dentures and Partials

Full Dentures and partial dentures are warranted for a period of two (2) years. Accidents such as dropping your denture are not covered. *Due to the nature of dentures, we cannot guarantee your comfort or your ability to accommodate these artificial appliances*. They may require additional services such as adjustments or re-lines to maintain. Those are not included as they are considered maintenance. We will not reconstruct, repair, reline or replace the denture free of charge, due to any of the following: loss, discoloration, excessive wear (for example, excessive grinding of teeth), inappropriate use (for example, any use not prescribed by the dentist), neglect or abuse.

CONDITIONS

- You must maintain uninterrupted membership in our practice.
- Keep your prescribed regular continuing care appointments (with no appointment carrying more than 30 days), periodontal and regular cleanings and receive regular professional in-office fluoride treatments at every preventative office visit.
- Maintain your account in good standing.
- Have all recommended treatment(s) performed by one of our doctors, including the use of bruxism guards if recommended.
- This warranty does not include anything not mentioned above, including gum line desensitization, night guards, nor does it cover damage to teeth or dental prostheses caused by accidents, trauma, neglect or improper use (grinding, clenching, chewing ice or biting non-food items)

Patient Signature: _____ **Date**: _____

v 01.03.01

No Show/Cancellation Policy

We recognize that everyone's time is valuable; patients and doctors alike. For that reason, we kindly request a 48-hour notice if you must cancel an appointment. Failure to appear to a scheduled appointment not only compromises your health, but inconveniences other patients who may have requested an office visit during your scheduled appointment time. We also understand that emergencies happen and will do our best to accommodate you in any way that we can in case of such an emergency. **Therefore, if you cancel within 24 hours or no show an appointment, you will be asked to leave a credit card on file.** If you fail to show up to your future scheduled appointments or cancel/reschedule the same day of that appointment, your credit card on file will be charged a **non-refundable fee of $75.00**. This card will NOT be used to collect past due balances unless you give your consent to do so. If you have an appointment on a Monday that must be canceled over the weekend, please contact us via email or by calling and leaving a voicemail at the office's main phone number so that you will not be subject to the cancellation fee.

If you accumulate 3 cancellations/no show appointments with less than 24 hours' notice within the course of a 12-month period, you may be required to pay 100% of your patient portion upon scheduling an appointment for restorative treatment.

By signing here, you are acknowledging that you have thoroughly read and understand our payment on file and no show/missed appointment policy.

_____ _____

Signature **Date**