



Home phone# _____ Cell # _____ Work# _____ Ext: _____

Patient Information

Patient Name: _____ Date: ? _____
Last First MI
 Male Female Married Single Child Other _____
Birth Date: _____ Social Security #: _____
Address: _____
Street Apartment #
City State Zip Code
E-mail _____ Best time to call: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Family/Relative
 Direct Mail Ad. Website Search Engine Insurance Directory Work Other _____
Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment
Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment
Employer Name: _____ Occupation: _____
Address: _____
Street City State Zip Code

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____



Name _____

Date _____

1. How did you find your way to our practice/ who may we thank for referring you?

2. How can we help you?

- _____ Improve the appearance of your teeth/smile
- _____ Overall dental health and prevention of tooth loss
- _____ Toothache/ TMJ

3. How have your dental experiences been in the past?

- _____ Excellent _____ Mediocre _____ Frightening/painful
- If frightening, what causes this?

What can we do to help you with this?

4. Have you had regular checkups and cleanings over the past several years? yes _____ no _____

When was your last cleaning? _____

If applicable, why have you neglected your dental health so long?

- _____ Money _____ Time _____ Procrastination _____ Pain/Fear

5. Why did you leave the dental office that treated you previously?

How can we improve/resolve this problem in our office, if possible?

6. Have you lost any teeth? yes ___ no ___ If yes, has it ever recommended that they be replaced? yes ___ no ___

Do any member of your family wear dentures? yes ___ no ___

If yes, did they loose them at a young age? _____

7. Do your gums ever bleed when you brush? yes ___ no ___ How often do you brush? _____

Do you floss? yes ___ no ___ How often? _____

8. Do you think your breath is as fresh as it could be? yes ___ no ___

9. Do you like your teeth/smile? yes ___ no ___ What would you change if you could?

Methods discussed _____



Financial Policy

For patients with dental insurance, we are happy to bill your insurance company as a courtesy to you. We ask that you pay your estimated portion of the balance at the time of your visit. We will provide estimates as accurately as possible, however, please understand that we cannot guarantee these estimates. They are based solely on the information given to us by you and your insurance company. In order for us to bill your insurance properly, it is necessary for you to provide accurate and complete information at the time of your first visit. Please understand that the balance of your treatment, regardless of your insurance compensation, is your responsibility.

For patients without dental insurance, we will expect payment at the time of service. Please let us know if there are any concerns at the time we present your treatment plan. We offer various options of payments, including “Care Credit” financial services. For further detail see the office manager.

It is not our policy to carry outstanding balances, therefore any accounts that have not been paid in full by **60 days** after treatment will be assessed an **18%** per annum interest charge, calculated on the first of each month.

In the event collection proceedings are instituted to enforce payment of fees, you are responsible for any attorney fees and associated court cost necessary for collection. There is a **\$35.00** dollar fee for all **returned checks**.

Appointments are scheduled on an individual basis, reflecting the amount of time needed to complete specific treatment. We do, however, realize that everyone has busy schedules. If you need to change or cancel an appointment, we ask that you call us no later than **48 hours** in advance, so that this time may be used for other patients in need. Failure to do so may result in a **\$60.00 dollar** charge for the **appointment missed**. (Extensive procedure cancellation charges may be higher due to the greater length of time reserved.)

Print Name

Signature

Date