WELCOME TO OUR OFFICE!

Thank you for trusting us with your dental care! We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

PATIENT INFORMATION

Name _____ **Home Phone** _____ **Cellphone** _____

SS # _____ **DOB** _____ **Age** _____ **Sex** _____ **Marital Status** _____

Address _____ **Apt #** _____ **City** _____ **State** _____ **Zip** _____

Employer _____ **Work Phone** _____

Spouse's Name _____ **Spouse's Employer** _____

Person to Notify in Case of Emergency _____ **Phone** _____

Relative or Friend not Living with You _____ **Phone** _____

Student: ☐ **Full Time** ☐ **Part Time** **School** _____ **City** _____

	Family Members	Age	Last Visit to the Dentist
Spouse			
Child			
Child			
Child			

RESPONSIBLE PARTY'S INFORMATION

Person Responsible For Account _____

Relationship To Patient _____ **Home Phone** _____ **Work Phone** _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

SS # _____ **Driver License #** _____

Employer _____ **Occupation** _____

Employer's Address _____ **City** _____ **State** _____ **Zip** _____

Dental Insurance ☐ **Yes** ☐ **No** **Secondary Insurance** ☐ **Yes** ☐ **No**

Insured's Name _____ **Insured's Name** _____

Relationship To Patient _____ **Relationship To Patient** _____

SS # _____ **DOB** _____ **SS #** _____ **DOB** _____

Employer _____ **Employer** _____

Ins. Co. Or Plan _____ **Ins. Co. Or Plan** _____

Union/Grp. Name _____ **Union/Grp. Name** _____

Grp. or Policy # _____ **Grp. or Policy #** _____

Date of Employment _____ **Date of Employment** _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ **Cash** ☐ **VISA** ☐ **Mastercard** ☐ **CareCredit** ☐ **GreenSky**

How did you hear about this office? ☐ **Friends/Family** ☐ **Flyer** ☐ **Google** ☐ **Yelp** ☐ **Facebook** ☐ **Instagram** ☐ **Other** _____

Why are you here today? ☐ **Routine Check-up** ☐ **Toothache** ☐ **Braces** ☐ **Improve Smile** ☐ **Other** _____

CONSENT TO FINANCIAL RESPONSIBILITY

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local or general anesthetic as may be deemed advisable by the dentist. I have also been explained the consequences of partial and/or no treatment. I hereby authorize my dentist to release any and all medical information (including dental information) to the above named insurance carrier for purposes of claims administration, evaluation, utilization, review, and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

I hereby authorize my insurance carrier to pay directly to the within names dentist(s) the dental benefits otherwise payable to me. I understand if my insurance company does not pay in full, I am responsible for the remaining balance. I understand some dental services I receive may require a co-payment from me. The amount of the co-payment will vary according to the insurance/dental plan I have and the procedure that is performed if my insurance/dental plan has a yearly deductible, I understand it must be satisfied before treatments begins. I also understand co-payments must be paid in full at the time of treatment. A finance charge of 15% per month (18% per annual) will be charged on the unpaid principal balance on all accounts not paid within 30 days of the date of service.

I further understand dental services not covered by my insurance/dental plan may be prescribed in certain cases by the attending dentist. Usual, customary and reasonable fees will be charged for such services.

I also understand there will be a charge for any missed appointment which is no canceled within 24 hours in advance.

Patient/Guardian Signature _____ **Date** _____

Guardian Signature _____ **Date** _____

A+ Dentistry FOR KIDS

A+ Dentistry FOR KIDS

	Blood Pressure	Date
Year 1		
Year 2		
Year 3		

Insurance	
Name	Date of Birth

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental concern, but they are all associated with proper oral health care. Please answer each question and make YES or NO as appropriate.

Medical History

YES NO

1. Are you in good health? ☐ ☐
2. Are you now under the care of a physician? ☐ ☐

   If so, what is the condition being treated? _____

   Physician name/ phone # / address _____
3. Have you ever had any serious illness or operation? ☐ ☐

   If so, what illness or operation? _____
4. Have you ever been hospitalized? ☐ ☐

   If so, what was the problem? _____
5. Are you taking medicine? Or any recreational drugs (ecstasy, cocaine, etc) ☐ ☐

   If so, What? _____ What dosage? _____
6. Are you sensitive or allergic to any drugs? ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ ☐

   Other: If other, what drug(s)? _____
7. Do you have, or have you had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart Murmur	☐	☐	Joint Replacement	☐	☐	Epilepsy or Seizures	☐	☐	Anemia	☐	☐	Liver Disease
☐	☐	High Blood Pressure	☐	☐	Allergies or Hives	☐	☐	Heart Ailments or Attack	☐	☐	Ulcers	☐	☐	Sinus Trouble
☐	☐	Radiation Therapy	☐	☐	Cortisone Medicine	☐	☐	Hepatitis or Jaundice	☐	☐	Glaucoma	☐	☐	Blood Disease
☐	☐	Rheumatic Fever	☐	☐	Excessive Bleeding	☐	☐	Fainting Spells or Seizures	☐	☐	Arthritis	☐	☐	Drug Addiction
☐	☐	Tuberculosis (TB)	☐	☐	Latex Allergy	☐	☐	Chemotherapy (Cancer,Leukemia)	☐	☐	Emphysema	☐	☐	Kidney Disease
☐	☐	Cardiac Pacemaker	☐	☐	Path in Jaw joints	☐	☐	Venereal Disease (Syphilis, Gonorrhea)	☐	☐	Cold Sores	☐	☐	HIV/AIDS
☐	☐	Nervous Disorders	☐	☐	Respiratory Disease	☐	☐	Artificial Prosthesis	☐	☐	Bruise Easily	☐	☐	Asthma
☐	☐	Thyroid Disease	☐	☐	Mental Disorder	☐	☐	Angina Pectoris	☐	☐	Head Injuries	☐	☐	Hemophilia
☐	☐	Tumors and Growths	☐	☐	Psychiatric Treatment	☐	☐	Congenital Heart Lesions	☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Blood Transfusion	☐	☐	Cerebral Palsy	☐	☐	Heart Surgery (Valve Replacement)	☐	☐	Prosthetic Joints			

YES NO

8. Do you have any disease, condition or problem not listed that you think we should know about? ☐ ☐

   If so, what? _____
9. Do you smoke? If yes, how much per day? _____ ☐ ☐

YES NO

10. Are you currently taking, or have you ever taken the drug Phen-Phen? ☐ ☐
11. (Women) Is there a possibility you may be pregnant? ☐ ☐
12. (Women) Do you have any problems associated with your menstrual period? ☐ ☐
13. (Women) Do you take birth control pills? ☐ ☐

Dental History

1. Have you ever had a local anesthetic? ☐ ☐
2. Have you ever had an unfavorable reaction from a local anesthetic? ☐ ☐
3. Have you had any serious trouble associated with any previous dental treatment? ☐ ☐

   If so, explain: _____
4. How long since your last full mouth X-rays? _____
5. How long since your last dental treatment? _____
6. Is any current dental problem the result of an accident? ☐ Yes ☐ No When _____
7. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

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

Patient/Guardian Signature: _____ Date: _____ Doctor Signature: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____ Doctor Signature: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____ Doctor Signature: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____ Doctor Signature: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____ Doctor Signature: _____ Date: _____