elite
The Pinnacle of Family & Cosmetic Dentistry

Patient Information

Patient name: _____ Date: _____

Last First MI

❒ Male ❒ Female ❒ Married ❒ Single ❒ Other

Social Security#:_____ Birth Date: _____ Driver License#: _____ State:

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

Email: _____

Home Street Address: _____

City, State, Zip: _____

Patient Employed by _____Occupation _____

In case of emergency who should be notified?_____

Whom may we thank for referring you?_____

Spouse Information

Spouse Name: _____

❒ Male ❒ Female

Social Security#: _____Birth Date: _____Driver's License#_____State _____

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

Home Street Address:_____

City, State, Zip: _____

Employer Name: _____Occupation: _____

Dental Insurance

Is patient covered by Dental Insurance ❒ Yes ❒ No

Subscriber Name _____Relation to Patient _____Birth Date _____

Address & phone (If different from patient)_____

Insurance Company & address _____

Subscriber Employed by _____Business Phone _____

ID # (listed on insurance card) _____ Group # _____ Phone _____

Dental History

Date of last dental care and former dentist_____

Reason for today's visit_____

Check (✓) if you have had problems with any of the following:

❒ Bad Breath
❒ Bleeding gums
❒ Clicking or popping jaw
❒ Food collection between teeth
❒ Grinding Teeth
❒ Loose teeth or broken fillings
❒ Periodontal treatment
❒ Sensitivity to cold
❒ Sensitivity to hot
❒ Sensitivity to sweets
❒ Sensitivity when biting
❒ Sores or growths in your mouth

How often do you floss? _____How often do you brush?_____

Parent or Guardian

Parent or Guardian Information - Person Responsible for the Account

The following is for: ❒ Parent ❒ Guardian

Name: _____

❒ Male ❒ Female ❒ Married ❒ Single ❒ Other: _____

Social Security#: _____ Birth Date: _____ Driver's License# _____ State _____

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

Home Street Address: _____

City, State, Zip: _____

Employer Name: _____ Occupation: _____

Street, City, State, Zip _____

Second Parent or Guardian Information The following is for: ❒ Parent ❒ Guardian

Name: _____

❒ Male ❒ Female ❒ Married ❒ Single ❒ Other: _____

Social Security#: _____ Birth Date: _____ Driver's License# _____ State _____

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

Home Street Address: _____

City, State, Zip: _____

Employer Name: _____ Occupation: _____

Street, City, State, Zip _____

Release of Information

I hereby authorize the release of my Protected Health Information acquired in the course of my examination or treatment to my insurance company to secure payment for services. This information may be shared via written communication or electronic transmission, including emails without special encryption, to my insurance company. Further, I acknowledge and release my protected health information to other dental service providers and specialist required to participate in my oral and overall healthcare.

I further authorize that the below-named parties have access to my protected health information and do acknowledge any party providing financial responsibility will have access to my personal health information and financial standing in the office:

Name: _____ **Relationship to patient:** _____

Name: _____ **Relationship to patient:** _____

Name: _____ **Relationship to patient:** _____

Signature of Patient/Legal Guardian: _____ **Date:** _____

Please Initial

Authorization

_____ I acknowledge I have received a copy of the HIPAA Policy.

_____ I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

_____ I authorize the dentist to release all information necessary to secure the payment of benefits.

_____ **I understand that I am financially responsible for all charges whether or not paid by insurance.**

_____ I have received a copy of the financial policy.

_____ I have read the above conditions of treatment and payment and agree to their content.

Signature _____ **Date** _____

Medical History: Although dental personnel primarily treat the area around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you receive. Thank you for answering the following questions:

Patient Name: _____Date of last Medical Exam:_____
Current Physician: _____ Physician Phone Number: _____

Are you taking any medications or supplements? Y____ N____
If Yes, please list any medications or supplements (use back of paper if needed)
_____
_____

	Y	N
Have you ever been hospitalized or had a major operation?	☐	☐
Have you ever had a serious head or neck injury?	☐	☐
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing *bisphosphonates*?	☐	☐
If yes, specify Oral or IV? _____		
Are you on a special diet? _____	☐	☐
Do you use Tobacco? If yes, dip or smoke? _____	☐	☐
Do you use controlled substances?	☐	☐
Have you recently traveled out of the country? ___If so, when? _____		

Are you Allergic to Any of the Following:?
☐ Aspirin ☐ Codeine
☐ Penicillin ☐ Latex
☐ Local Anesthetics (i.e. Novocaine) ☐ Sulfa Drugs
☐ Other(s) _____

Women:	Y	N
Are you pregnant or trying to become pregnant?	☐	☐
Are you taking contraceptives?	☐	☐
Are you nursing?	☐	☐

CHECK ALL THAT APPLY:

	Have/ Had/Family		
Cardiovascular:			
Angina (Chest Pain)	☐	☐	☐
Artificial Heart Valve	☐	☐	☐
Congenital Heart Disorder	☐	☐	☐
Heart Attack/Failure	☐	☐	☐
Heart Murmur	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Low Blood Pressure	☐	☐	☐
Irregular Heart Beat/AFIB	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Pace Maker	☐	☐	☐
If yes, what year was it implanted? _____			
Stroke	☐	☐	☐
Digestive/Urinary/Reproductive:			
Acid Reflux/GERD	☐	☐	☐
Celiac Sprue	☐	☐	☐
Colon Removal	☐	☐	☐
Herpes? Oral____ Genital ____	☐	☐	☐
History of C-section? Year_____	☐	☐	☐
Human Papilloma Virus (HPV)	☐	☐	☐
IBS/Ulcerative Colitis	☐	☐	☐
Stomach/Intestinal Disease	☐	☐	☐
Sexually Transmitted Disease	☐	☐	☐
Ulcers	☐	☐	☐
Endocrine/Internal:			
Cancer	☐	☐	☐
Type?_____			
Chemotherapy	☐	☐	☐
When_____?			
Radiation Treatment	☐	☐	☐
When? _____			
Diabetes	☐	☐	☐
Type? ___ What is your most recent A1C?_____			

	Have/ Had/Family		
(Endocrine cont.)			
Excessive Thirst	☐	☐	☐
Fainting Spells/Dizziness	☐	☐	☐
Hypothyroidism/Thyroid Disease	☐	☐	☐
Hypoglycemia	☐	☐	☐
Kidney Problems	☐	☐	☐
Pancreatitis	☐	☐	☐
PCOS	☐	☐	☐
Renal Dialysis	☐	☐	☐
Swelling of Limbs	☐	☐	☐
Tumors or Growth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Do you have a rescue inhaler? Y___ N____			
When last used? _____			
Breathing Trouble/Easily Winded	☐	☐	☐
Chest Pain	☐	☐	☐
Emphysema/COPD	☐	☐	☐
Frequent Cough	☐	☐	☐
Sleep Apnea	☐	☐	☐
Do you wear a c-pap? Y___ N____			
Tuberculosis	☐	☐	☐
Muscular/Skeletal/Skin:			
Arthritis/Gout	☐	☐	☐
Artificial Joint	☐	☐	☐
Which Joint/When? _____			
Bruise Easily	☐	☐	☐
Cortisone Treatment	☐	☐	☐
Hives or Rash	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Shingles	☐	☐	☐
Osteoporosis/Osteopenia	☐	☐	☐

	Have/ Had/Family		
Head/Neck/Throat/Mou...			
Canker Sores	☐	☐	☐
Cold Sores/Fever Blisters	☐	☐	☐
Difficulty Swallowing	☐	☐	☐
Dry Mouth	☐	☐	☐
Frequent Headaches	☐	☐	☐
Lump in Throat	☐	☐	☐
TMJ/Jaw Pain/Bruxism	☐	☐	☐
Other:			
ADD/ADHD	☐	☐	☐
Addiction/Chemical Dependency/ Alcoholism	☐	☐	☐
Alzheimer 's disease	☐	☐	☐
Anemia/Hemophilia	☐	☐	☐
AIDS/HIV Positive	☐	☐	☐
Anaphylaxis	☐	☐	☐
Depression/Anxiety	☐	☐	☐
Other Psychiatric? _____	☐	☐	☐
Epilepsy/Seizures/Convulsions	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis	☐	☐	☐
What type?_____			
Hiatal Hernia	☐	☐	☐
High Cholesterol	☐	☐	☐
Inflammatory disease	☐	☐	☐
Type? _____			
Liver Disease	☐	☐	☐
Lupus	☐	☐	☐
Recent Weight Loss	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Scarlet Fever	☐	☐	☐
Seasonal Allergies	☐	☐	☐
Sjögren's Syndrome	☐	☐	☐
Sinus Trouble	☐	☐	☐

Have you ever had any illness or procedure not listed above? Yes____No____If yes, please explain:
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____Date: _____

Office Use Only: BP _____Clinician Signature _____ Date: _____

_____

*** You May Refuse to Sign This Acknowledgment***

I have reviewed a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (Please Specify)**

_____

_____

_____

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Office Financial Policy

- **We try to make your dental care as cost-efficient as possible. One measure we have taken to keep cost down is to minimize our billing and accounting; therefore, we ask for the estimated co-payment at the time of service. Financial arrangements must be established before our office can proceed with any recommended treatment.**

- **All patients who are seen in our office for a Comprehensive Exam are provided with a Treatment Plan. This is an ESTIMATE of the anticipated cost of your dental treatment. Your Treatment Plan will include an estimated insurance payment based on your dental coverage. If your carrier's payment differs from our estimate, you are responsible for the balance. In the case of an overpayment, you are entitled to a prompt refund. Any claims over 90 days, become your responsibility.**

- **If after insurance pays, there remains a balance on your account, you will receive a *Statement for Services*. This is due and payable upon receipt of statement. There will be a $35 charge for returned checks.**

- **In cases of divorce or separation, the parent bringing the child is responsible for payment.**

- **We request that you be on time for your appointments. If you are more than 10 minutes late you may have to reschedule your appointment.**

- **If it becomes necessary to reschedule an appointment you are expected to call 48 hours before your appointment. No-Shows and late cancellations are not acceptable. Failure to come in for your appointment not only compromises your health, but inconveniences other patients who may have requested an office visit during your scheduled appointment. Except in the case of an emergency, there is a $100 fee for all no-show and late cancellations. The fee collected will then be donated to Donated Dental Services, a charitable organization.**

Our practice firmly believes that a good Doctor/patient relationship is based upon a clear understanding of office policies and an open line of communication. We make every effort to clarify any misunderstandings you may have concerning your account balance or our financial policies. We hope to avoid any possible disagreements over payment for professional services. Our patients and our relationships with our patients are very important to us. If you have any questions or need assistance, please contact us immediately.

Signature _____ **Date** _____ **Relationship to patient** _____

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Smile Evaluation

Name: _____

1. **Do you like the appearance of your teeth? Yes_____ No_____**
   If no, explain: _____

2. **Are you happy with the color of your teeth? Yes_____ No_____**
   If no, explain: _____

3. **Would you like for your teeth to be whiter? Yes_____ No_____**

4. **Would you like for your teeth to be straighter? Yes_____ No_____**

5. **Do you have any spaces between your teeth that you would like to have closed? Yes _____No_____**
   If so, where? _____

6. **Would you like for your teeth to be longer? Yes_____ No _____**

7. **Do you like the shape of your teeth? Yes_____ No _____**
   If no, explain: _____

8. **Do you have missing teeth that you would like to replace? Yes_____ No_____**
   If yes, explain: _____

9. **Do you have old silver fillings that you would like to replace with tooth-colored fillings? Yes _____No_____**
   If yes, explain: _____

10. **If you could change anything about your smile, what would you change?**

    _____

    _____