

Patient Health Record

Date _____
Name(last, first, middle initial) _____
Address(street,apt.#,city,state,zip code) _____
Home Phone _____ Work Phone _____
Date of Birth _____ Your Social Security Number _____
Marital Status(circle one): single married
Spouse's Name _____
Your Employer _____ Occupation _____
Name and address of Dental Insurance Co: _____

Insured person's name (ex: you, spouse/parent's name) _____
Insured person's social security number _____
Dental Insurance Group or Account Number _____
Referred by _____

Dental Health

When was your last dental exam/cleaning? _____
Have you had any serious problems with dental treatment? Please explain if so.

Are you having any pain/problems at this time? _____

Do your gums bleed when you brush or floss? Yes No
Have you lost any teeth? Yes No If yes, when? _____
Are you having any TMJ problems (clicking or pain in the jaw muscle)? Yes No
Would you like to change the chape or alignment of your teeth? Yes No
Would you like to have whiter teeth? Yes No
Why did you leave your last dentist? _____

Financial Policies

The major objective of this office is to provide you with the best quality dental care available anywhere. This service is based on a friendly and professional understanding between the doctor and patient. The following statements are made to acquaint you with our financial policy.

Once you have provided our office with your current dental insurance information, we will be happy to file all necessary claims for you at no extra charge. However, the patient needs to realize that the insurance agreement is between the insurance company and the patient and not with the doctor. We request those patients with insurance to pay their respective co-payments at the time of treatment. If there is a balance after insurance responds the patient is required to pay that amount.

Patients not having dental insurance will be required to pay for services when treatment is rendered. For cases requiring multiple visits, 1/2 of the total fee will be due at the initial visit. Full payment must be made at completion of treatment unless other arrangements have been made.

Please understand that if payment is not made when due, the account may be turned over for collections. You will be responsible for any and all costs associated with the collection procedure, including but not limited to billing costs, collection fees, lawyer's fees, and court costs.

NAME _____ DATE _____