— Quality Dental Care —

WELCOME TO OUR PRACTICE

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely:

ABOUT YOU

Today's Date: _____

Name: _____

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ **Age:** ___ **SS #:** _____

Home Address: _____
Apt/Condo#

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: _____ **Cell #:** _____

WK #: _____ **Ext** _____ **DL #:** _____

E-Mail: _____

Employer: _____

Where & when are the best times to reach you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____
(please circle)

Last Visit Date: _____

How did you hear about our office?

☐ Radio ☐ Mailer ☐ Yellowbook ☐ TV

☐ Google ☐ Sign ☐ Other _____

☐ Patient _____

Have you heard our last radio announcement? ☐ No ☐ Yes

SPOUSE INFORMATION

Their Name: _____

Employer: _____

WK #: _____ **Ext** _____ **Cell #:** _____

Birthdate: ___/___/___ **Age:** ___ **SS #:** _____

E-Mail: _____

RESPONSIBLE PARTY

Person Responsible for Account: _____

WK #: _____ **Ext** _____ **Cell #:** _____

Billing Address: _____

Relationship: _____ **SS #:** _____

Employer: _____ **DL #:** _____

Our goal is to make your visit to our office enjoyable. In order to give you the service you expect and desire, please let us know what is important to you to help us improve your dental visit.

_____

_____

_____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (plan, Local or Policy #): _____

Insured's Name: _____ **Relation:** _____

Birthdate: ___/___/___ **Insured SS #:** _____

Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (plan, Local or Policy #): _____

Insured's Name: _____ **Relation:** _____

Birthdate: ___/___/___ **Insured SS #:** _____

Insured's Employer: _____

EMERGENCY CONTACT

In the event of an emergency, please contact:

Their Name: _____ **Relation:** _____

WK #: _____

Cell #: _____

MEDICAL HISTORY

Do you have a personal physician? ☐ No ☐ Yes

Physician's Name: _____

Phone #: _____ **Date of last visit:** _____

CONTINUED ON BACK OF FORM

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

_____

Are you currently in pain? ☐ No ☐ Yes

If yes, please explain: _____

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ No ☐ Yes
If so, please explain: _____

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)? ☐ No ☐ Yes

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ No ☐ Yes Interested in whitening? ☐ No ☐ Yes

Do your gums bleed? ☐ No ☐ Yes

How many times a week do you floss? _____ a day do you brush? _____

Type of Bristles? ☐ Hard ☐ Medium ☐ Soft

Thank you for filling out this form completely. It will enable us to help you more effectively. I understand my information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my account or medical status. If you have any questions at any time, please feel free to ask us. We are happy to help.

SIGNATURE AUTHORIZATION

**I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

**6 month appointments routinely consists of an exam, prophylaxis (cleaning), and a fluoride treatment (for all children under 16 and as recommended by Doctor otherwise). Bitewing x-rays will be taken at least once per year as recommended by Doctor, and a full mouth x-ray will be updated every three years. These are our standards of care to give each patient the best service we can provide. Each employer's policy has different allowances and limitations. Since it is the patient who has the contract with the insurance, it is your responsibility to know your insurance coverage. If you have any questions regarding your treatment, you must ask before treatment is rendered.

**I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental insurance claims.

**I authorize payment of the dental benefits otherwise payable to me directly to Quality Dental Care.

**I understand that all payments at the time of the appointment are estimates only and I am responsible for all charges incurred on my account that are not covered by insurance. I understand that all balances on my account are due in full within 60 days of date of service regardless of insurance payment. A service charge of 1.33% per month, 16% APR, with a minimum of $1.00 will be added to all overdue accounts. A late fee of $20.00 will be added to all accounts unpaid for 90 days. I agree to be liable for all legal and collection fees.

**Since appointment times are reserved just for the patient scheduled, we require 24 hours notice to change appointments without a charge. All appointments changed with less than the required notice are subject to a $50.00 cancellation fee.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**I acknowledge that I have received access to the office's Notice of Privacy Practices.

**I authorize the release of any of my dental information including proposed treatment plans, procedure fees, and dental history to the following individuals:

❖ _____ NAME _____ RELATIONSHIP

❖ _____ NAME _____ RELATIONSHIP

❖ _____ NAME _____ RELATIONSHIP

_____
PRINT PATIENT'S NAME

_____
DATE

_____
SIGNATURE