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General & Reconstructive Dentistry
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ABOUT YOU

Today's Date: ___/___/___

Patient's Name: _____

☐Male ☐Female Drivers License#_____

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

Mailing address: _____

_____

Home Phone: (___) _____

Work Ph:(___) _____Cell Ph:(___) _____

E-mail Address: _____

Referred By: _____

Employer: _____

Employer's Address: _____

_____

Occupation: _____

Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name: _____

ACCOUNT INFORMATION

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____

SS#: _____

Drivers License #: _____

Phone #: (____) _____

Payment method: ☐ Cash ☐ Check

_____

☐ Credit Card (Enter card # above)

_____ I hereby authorize assignment of my insurance
Initials rights & benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

PLEASE CONTINUE ON BACK →

INSURANCE INFO

Primary Dental Insurance:

Co. Name: _____

Address: _____

_____

Phone #: (____) _____

Insured's Employer: _____

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

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's SS #: _____

Secondary Dental Insurance:

Co. Name: _____

Address: _____

_____

Phone #: (____) _____

Business Name#: _____

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

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's SS #: _____

IN THE EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (____) _____

Cell Phone #: (____) _____

Who is your Medical Doctor? _____

Medical Doctor's Ph. #: (____) _____

DENTAL INFORMATION

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation Are you in pain? ☐ No ☐ Yes, How Long? ___

Please indicate (√) any of the following problems: ☐ Blisters/Sores in or around the mouth. ☐ Locking Jaw

☐ Discomfort, clicking or popping in jaw. ☐ Lost/Broken Filling(s) ☐ Broken/Chipped tooth

☐ Red, swollen or bleeding gums. ☐ Teeth grinding ☐ Stained teeth / Bad breath

☐ Sensitive tooth, teeth or gums. ☐ Ringing in ears ☐ Other: _____

Do you require pre-medication for dental work? ☐Yes ☐No ☐Don't know

Previous Dentist: _____ Last Dental exam: ___/___/___ Last Dental X-rays: ___/___/___

How would you rate your smile? (WORST) 1 2 3 4 5 6 7 8 9 10 (BEST)

CURRENT MEDICATION LIST

Please list **ALL MEDICATIONS** you are currently taking:

MEDICINE: DOSAGE: REASON:

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ☐ Yes ☐ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Thyroid Problems	Y N Cancer / Tumors	Y N Cosmetic Surgery
Y N Heart Surg. / Pacemaker	Y N Kidney Problems	Y N Shingles	Y N Radiation Treatment
Y N Heart Murmur	Y N Liver Problems	Y N Hepatitis (A, B, C)	Y N Chemotherapy
Y N Rheumatic Fever	Y N Respiratory Problems	Y N HIV+ / AIDS / ARC	Y N Pregnant now
Y N Mitral Valve Prolapse	Y N Sinus Problems	Y N Arthritis/Rheumatism	Y N Trying to Conceive
Y N Artificial Valves	Y N Stomach Problems/Ulcers	Y N Artificial Bones/Joints	Y N Diabetes / Hypoglycemia
Y N Heart Disease	Y N Venereal Disease	Y N Emphysema /Asthma	Y N Difficulty Breathing
Y N Congenital Heart Defect	Y N Chemical Dependency	Y N Fainting/Seizure/Epilepsy	Y N Leukemia
Y N Tuberculosis TB	Y N High/Low Blood Pressure	Y N Frequent Neck Pain	Y N Scarlet Fever
Y N Blood Thinners	Y N Bleeding Problems/Hemophilia	Y N Nervousness	Y N Jaw Pain TMJ / TMD
Y N Back Problems	Y N Severe / Frequent Headaches	Y N Gastric Bypass	Y N Dialysis

List **all** other surgeries or medical conditions you have or ever had: _____

_____

_____

Are you allergic to any of the following? ☐ **NO** ☐**YES** ☐ Latex ☐ Penicillin/Amox ☐Tetracycline

☐ Aspirin ☐ Dental Anesthetics/Epinephrine ☐ Foods: _____ ☐Others: _____

Do you use tobacco? ☐No ☐Yes/how used? _____ How much? _____ How long? _____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. We require 24 business hours notice for all rescheduled or cancelled appointments, to avoid $50 fee.
- I have read & understand the privacy policy. I authorize the staff to perform any necessary services needed during diagnosis & treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____

☐Adult Patient ☐Parent or Guardian ☐Spouse

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dandubedentistry.com

FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. *If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.*

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring proof of insurance to each appointment.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Third party, extended payment financing is available upon your request and approval through Springleaf Financial and CareCredit.

Returned checks and balances older than 60 days will be subject to collection fees (30% of balance) and finance charges at the rate of 1.5% per month (18% annually).

A scheduled appointment is a commitment of time between you and our practice. We have reserved that time ***just for you.*** *When appointments are missed or cancelled, that is time permanently lost. Therefore, our practice will charge $50 for appointments that you do not keep and for appointments that you do not cancel with a* ***48-hour notice****.*

_____ _____

Printed Name & Signature of Patient or Responsible Party Date

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