



Patient Information

Mr. Mrs. Ms. Dr. Male Female Single Married Divorced Widowed

First Name → Middle Name Last Name Preferred Name

Home Address → City State Zip

Social Security Number → Drivers License Number Date of Birth

Home Phone → Cell Phone Email

Occupation → Employer Name Employer Phone

Employer Address → City State Zip

Person Responsible For Account ~ Check Here If Same As Above

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Dental Insurance Information

Check here if you do not have Dental Insurance Check here if you previously provided information

Insured's First & Last Name → Date of Birth Social Security

Name of Insured's Employer → Patient Relationship To Insured

Insurance Company → Phone Subscriber ID # Group ID #

Insurance Company Address → City State Zip

Referral Information

How did you **first** hear about our office? Another Patient (relative) Another Patient (friend) New Patient Flyer

Another Dental or Medical Office School Work Church Drive By Office Google Yelp Yahoo

Yellow Pages Employee Community/Charity Event Insurance Company Health/Benefits Fair or Event

If you were referred to us by someone please write their name.

DENTAL HISTORY

Please check any of the following problems that apply to you.

- Sensitivity (hot, cold, sweet)
- Tooth pain or discomfort when chewing
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- Dentures
- Partial Dentures
- Braces
- Periodontal (gum) treatments

Please share the following dates:

Your last cleaning _____/_____/_____

Your last oral cancer screening _____/_____/_____

Your last complete X-Rays _____/_____/_____

Name of Previous Dentist _____ City/State _____ Phone _____

What is the most important thing to you about your future smile and dental health?

If you could whiten your teeth for a cost anyone could afford, would you do it? Yes No

Do you smoke or use chewing tobacco?

How much? _____ For how long? _____

If I could change my smile, I would:

- Make them brighter
- Make them straighter
- Close spaces
- Replace black metal fillings with tooth-colored fillings
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

What is the most important thing to you about your dental visit today?

MEDICAL HISTORY

Please check any of the following that apply to you: (* indicates conditions that may contribute to Gum Disease 'Oral Health')

- | | | | |
|-------------------------------------------------|-----------------------------------------------------|--------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Diabetes * | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dizziness | <input type="checkbox"/> HIV | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alcohol Addiction | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Allergies (Seasonal) | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaw Joint Pain | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis * | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Conditions * | <input type="checkbox"/> Mitral Valve Prolapse * | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Lesions (Congenital) | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease * | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Periodontal Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Phen Fen (1 month +) | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Chemotherapy * | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Radiation (head/neck) | <input type="checkbox"/> Weight-loss Surgery |
| <input type="checkbox"/> Dementia/Alzheimers | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Pregnant Currently | <input type="checkbox"/> Other |

Do you have any of the following drug allergies?

- | | |
|-------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Darvon | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Percodan | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Local Anesthetic | Other (specify): _____ |

Is there any other medical or dental information we should know about? Pregnant? Nursing?

Print Name: _____

Signature (Patient or Guardian): _____ Date: _____

Dentist Signature: _____ Date: _____

Are you under a physician's care? Specifically, for what?

Are you currently taking any medications? Blood Thinners (including Aspirin and Fish Oil) or Biophosphates (medication for bone issues/cancer) Please list below.

Fairchance Dental Arts: Financial Guidelines

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any charges incurred.

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance **estimate** to you, however it is **not a guarantee that your insurance will pay exactly as estimated**. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to make sure your estimate is as accurate as possible.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
- We ask that you pay the deductible and co-payment if your treatment is *under \$250*, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, American Express or Discover at the time we provide the service to you. Outside financing is available upon approval. For co-payment over \$250, a financial arrangement will be made in writing.
- 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 a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial guidelines.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

PATIENT Signature (Parent of Child):

Date:



CONSENT FOR TREATMENT

I authorize the doctor and designated team members to gather the information necessary to make a thorough diagnosis of my dental needs. In general, diagnostics include radiographs, study models, periodontal measurements, photographs and/or other aids deemed appropriate by the doctor to make an accurate diagnosis. Radiographs are required to complete your examination, diagnosis, and treatment plan.

I understand there are risks involved in receiving dental treatment, as well as risks involved in choosing not to obtain the treatment recommended. I understand that I can ask for a complete recital of any possible complications.

The treatment specifically recommended for you will be explained to you in detail. It can include, but is not limited to, the following:

- Dental Cleanings (above the gum line)
- Periodontal Treatment (below the gum line)
- Fillings
- Crowns, Bridges, Veneers
- Implants
- Tooth Extractions
- Orthodontics
- Root Canal Therapy
- Temporomandibular Joint Dysfunction
- Sleep Apnea

I understand during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I give my permission to make any changes and additions as necessary.

I understand that I have the right to choose on the basis of adequate information, from alternative treatment plans that meet the doctor's professional standard of care. It is important to provide your dentist with an accurate medical history before, during and after treatment. It is equally important to follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I have read each paragraph above and consent to recommended treatment as needed.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____