

PATIENT INFORMATION

Patient Name _____ Male _____ Female _____
 Married Y/N _____ Date of Birth _____ Age _____ Soc. Sec. #: _____ Drivers Lic#: _____
 Spouse/Significant Other name: _____ Phone _____
 Children/Siblings residing with you _____
 Street Address _____ City _____ State _____ Zip _____
 Home Phone # _____ Work Phone # _____ Ext _____
 Cell Phone # _____ E-mail Address _____
 Preferred contact method (circle) Home Phone Cell Phone Work Phone Email Text Message
 Employer/School _____ Occupation/Department _____
 Full Time _____ Part Time _____
 Employer Address: _____ City _____ State _____ Zip _____
 Emergency Contact (not living with you) _____ Phone _____
 Date of Last Dental Visit _____ Date of Last Dental X-rays _____

BILLING INFORMATION

(Circle) Self Spouse Parent

Name _____ Date of Birth _____ Age _____
 Street Address _____ City _____ State _____ Zip _____
 Home Phone # _____ Work Phone # _____ Ext _____
 Cell Phone # _____ E-mail Address _____ Soc. Sec. #: _____
 Employer _____ Occupation _____
 Employer Address: _____ City _____ State _____ Zip _____

PRIMARY DENTAL INSURANCE

Subscriber Name _____
 Relationship to Patient _____
 Subscribers Date of Birth _____
 Subscribers SS/ID# _____
 Address (if different from patient) _____

 Subscribers Employer _____
 Insurance Company _____
 Group # _____

SECONDARY DENTAL INSURANCE

Subscriber Name _____
 Relationship to Patient _____
 Subscribers Date of Birth _____
 Subscribers SS/ID# _____
 Address (if different from patient) _____

 Subscribers Employer _____
 Insurance Company _____
 Group # _____

DENTAL HISTORY

Name _____ Age _____ Date _____

Please Check All that Apply:

- | | | | |
|--|---|--|---|
| <input type="radio"/> Toothache | <input type="radio"/> Bad previous dental work | <input type="radio"/> Dry or strained eyes | <input type="radio"/> Unusual habits with teeth |
| <input type="radio"/> Broken filling or tooth | <input type="radio"/> Gums bleed | <input type="radio"/> Shoulder, neck or headaches | <input type="radio"/> Wore braces |
| <input type="radio"/> Clench or grind teeth | <input type="radio"/> Gums tender | <input type="radio"/> Clench or grind teeth | <input type="radio"/> Previous gum treatment |
| <input type="radio"/> Food catches | <input type="radio"/> Growths, Sores | <input type="radio"/> Jaw joint pain | <input type="radio"/> Previous bite treatment |
| <input type="radio"/> Loose teeth | <input type="radio"/> Cold sores, fever blisters | <input type="radio"/> Clicking or popping of jaw | Sensitivity to: |
| <input type="radio"/> Floss breaks easily or hurts | <input type="radio"/> Cracked chapped lips | <input type="radio"/> Unable to open mouth wide | <input type="radio"/> Cold |
| <input type="radio"/> Bite or teeth have shifted | <input type="radio"/> Bad taste in mouth | <input type="radio"/> Jaw tires easily | <input type="radio"/> Hot |
| <input type="radio"/> Often bite cheek | <input type="radio"/> Sinus problems | <input type="radio"/> Hold things between teeth
(pipe, pencil, nails, pins) | <input type="radio"/> Sweets |
| <input type="radio"/> Frequent dry mouth | <input type="radio"/> Mouth breathe - Difficult
breathing through nose | <input type="radio"/> Bite fingernails | <input type="radio"/> Chewing |
| <input type="radio"/> Concerned about breath | | | |

Would you like whiter teeth? _____ Is there anything that bothers you (even just a little) about the appearance of your teeth or smile? _____

Please rate 1-10 how anxious you are about dental treatment (1 = totally relaxed) _____

Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) _____

How did you hear about our office? _____

MEDICAL HISTORY

Physicians Name: _____ Are you allergic to penicillin, aspirin, local anesthetics, latex, City: _____ Phone: _____ sulfa, codeine, other? _____

Have you ever been hospitalized for any reason? Please Describe: Do you Smoke? How much/day? _____

Are you taking any medications or drugs (including nutritional supplements?) Please list: (Continue on back of form if needed) _____

Pregnant? Due date: _____ Are you nursing? _____
Are you seeing a physician now or planning to see one for any reason? Please explain: _____

Please check all that apply:

- | | | | |
|---|---|---|---|
| <input type="radio"/> Allergies | <input type="radio"/> Fainting | <input type="radio"/> Jaundice | <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> Anemia | <input type="radio"/> Glaucoma | <input type="radio"/> Kidney Disease | <input type="radio"/> Rheumatism |
| <input type="radio"/> Arthritis | <input type="radio"/> Head Injuries | <input type="radio"/> Liver Disease | <input type="radio"/> Shortness of Breath |
| <input type="radio"/> Artificial Heart Valve/Joints | <input type="radio"/> Heart Attack | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Sinus Problems |
| <input type="radio"/> Asthma | <input type="radio"/> Heart Disease | <input type="radio"/> Mental Disorders | <input type="radio"/> Stomach Problems |
| <input type="radio"/> Blood Disease | <input type="radio"/> Heart Murmur | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Stroke |
| <input type="radio"/> Cancer | <input type="radio"/> Heart Problems | <input type="radio"/> Nervous Disorders | <input type="radio"/> Thyroid |
| <input type="radio"/> Chest Pains | <input type="radio"/> Heart Stents | <input type="radio"/> Other | <input type="radio"/> Tobacco Use |
| <input type="radio"/> Diabetes | <input type="radio"/> Hepatitis | <input type="radio"/> Pacemaker | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Dizziness | <input type="radio"/> High Blood Pressure | <input type="radio"/> Pregnancy | <input type="radio"/> Tumor |
| <input type="radio"/> Epilepsy | <input type="radio"/> HIV/AIDS | <input type="radio"/> Radiation Treatment | <input type="radio"/> Ulcers |
| <input type="radio"/> Excessive Bleeding | <input type="radio"/> Hypothyroid | <input type="radio"/> Respiratory Problems | <input type="radio"/> Venereal Disease |

Any other illnesses not checked above: _____

Any other illnesses not checked above: _____ {I will inform this office of any changes in my health status. I certify that the above information is completed and accurate to the best of my knowledge. }

Patient Signature _____ Date: _____

Provider Signature _____ Date: _____

APPOINTMENT GUIDELINES

We believe in the value of clear communication, as well as mutual understanding and respect prior to treatment rendered. It is our desire to provide high-quality dental care and individual attention for you in a timely manner. Your appointment time has been reserved especially for you and we make every effort to remind patients of their appointment as a courtesy. Therefore, if you break an appointment without 24 hours' notice, we do not have sufficient amount of time to rebook another patient in need of treatment. With this in mind, a **\$50.00 fee may be subject to the second missed appointment or cancellation less than 24 hours from you scheduled time.** This fee must be paid in full prior to any further appointment(s) scheduled.

(Initial)

FINANCIAL & DENTAL INSURANCE GUIDELINES

Any monies due directly from the patient for services rendered are due in full at the time of service unless other arrangements are made in advance. We accept all major debit/credit cards, cash and checks. There will be a **\$35.00 service charge** on all returned checks.

Understanding Dental Insurance is complicated for both the insured and the Doctor. When a patient gives us an insurance card we call the insurance company to get your benefit information-usually in the form of a fax which contains basic benefit coverage.

When we put together a treatment plan for needed dental work diagnosed by the Doctor, we are basing the patient portion off of the information provided by your insurance company. As a courtesy to our patients we will collect your estimated co-pay in full at the time of service and bill the insurance directly for their estimated portion of treatment.

If the insurance has not made their payment after 30 days of the claim being sent, we will supply the patient or guarantor with everything needed to contact their insurance in order to follow-up on their dental claim.

It is the mission of Dr. Lee, Dr. Kohler and every staff member that from the moment you step through our front door, you have the best dental experience possible. In order to achieve this, your help is required.

We are asking for everyone to help out and make sure their treatment is paid for in a timely fashion.

ANY BALANCE DUE AFTER 60 DAYS IS PAYABLE IN FULL FROM THE PATIENT WITHIN 10 DAYS OF NOTICE.

Signature

Date

AUTHORIZATION FOR SIGNATURE ON FILE

I _____ hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf. This "signature on file" will be valid from the date signed. A photocopy of this document may act as an original

Signature

Date