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| **Patient Information** |
| Date: |  |  |  | [ ] New Patient | [ ] Update |  |
| Patient: |  |  |  |  |  |  |
|  | Last | First | MI | Preferred | Title |  |
|  | [ ] Male [ ] Female | [ ] Child\* [ ] Student\*\* | [ ] Single [ ] Married [ ] Divorced [ ] Widowed |
| \*If Child, provide parent/guardian name(s) below: | \*\*If Student, please complete: [ ] Full-time [ ] Part-Time |  |
|  |  |  |  |  |  |
|  | Parent/Guardian Name(s) |  |  | School/Location |  |
| Patient Date of Birth: |  | Patient SSN: |  |  |
| Address: |  |  |  |
|  | Address Line 1 |  |  |  |
|  |  | Home: |  |  |
|  | Address Line 2 | Cell: |  |  |
|  |  |  |  | Other: |  |  |
|  | City | ST | ZIP Code | Pager: |  |  |
| E-Mail: |  | Fax: |  |  |
| Referral? | [ ] Yes [ ]  No | Referred by: |  |  |
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| **emergency Information** |
| In case of emergency, please provide information for the nearest relative or designated contact person not at the patient’s address: |
|  |  |  | Tel: |  |  |
|  | Name | Relationship |  |  |  |

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| **employment Information** |
| Employer: |  | Occupation: |  |  |
| Address: |  |  |  |
|  | Address Line 1 | Work: |  X |  |
|  |  | Direct: |  |  |
|  | Address Line 2 | Other: |  |  |
|  |  |  |  | Pager: |  |  |
|  | City | ST | ZIP Code | Fax: |  |  |
| E-Mail: |  |  |  |  |
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| **insurance Information** |
| Subscriber: |  |  |  |  |  |  |
|  | Last | First | MI | Preferred | Title |  |
| Subscriber Date of Birth: |  | Subscriber SSN: |  |  |
| Subscriber Employer: |  |  |
| Patient Relationship to Subscriber: | [ ] Self [ ] Spouse [ ] Child [ ] Other  |  |
| **Primary Insurance Carrier:** |  |  |
| Group/Policy No.: |  | ID No.: |  |  |
| Address: |  | Tel: |  |  |
|  |  | Toll-free: |  |  |
|  |  |  |  | Fax: |  |  |
|  | City | ST | ZIP Code |  |  |  |
| **Secondary Insurance Carrier:** |  |  |
| Group/Policy No.: |  | ID No.: |  |  |
| Address: |  | Tel: |  |  |
|  |  | Toll-free: |  |  |
|  |  |  |  | Fax: |  |  |
|  | City | ST | ZIP Code |  |  |  |

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| **Previous Dentist Information** |
| Dentist: |  | Telephone: |  |  |
| Clinic/Facility: |  |  |
| Address: |  |  |
|  |  |  |  |  |
|  | City | ST | ZIP Code |  |
| Reason for changing: |  |  |
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| **dental history** |
| Oral Health: [ ] Excellent [ ] Good [ ] Fair [ ] Poor |
| Date of Last Dental Visit: |  | Treatment Type:  |  |  |
|  |  |  |  |  |
| [ ] Y[ ] N | Are you currently having dental discomfort? If yes, explain: |  |  |
| [ ] Y[ ] N | Any unhappy/unpleasant dental experiences? If yes, explain: |  |  |
| [ ] Y[ ] N | Any injuries to mouth/teeth/head? If yes, explain: |  |  |
| [ ] Y[ ] N | Any missing teeth other than wisdom teeth or orthodontic extractions? |  |
| [ ] Y[ ] N | Have missing teeth been replaced? |  |
| [ ] Y[ ] N | Orthodontic appliances now or in the past? |  |
| [ ] Y[ ] N | Gums bleed when brushing or flossing? |  |
| [ ] Y[ ] N | Concerned about gum disease? History of gum disease? [ ] Y[ ] N |  |
| [ ] Y[ ] N | Any concerns about the appearance of your teeth? |  |
| [ ] Y[ ] N | Does it hurt to bite or chew? |  |
| [ ] Y[ ] N | Do you clench or grind your teeth? If so, do you wear a night guard or splint? [ ] Y[ ] N |  |
| [ ] Y[ ] N | Do you want to become a regular continuing care patient in our practice? |  |
| [ ] Y[ ] N | Do you want your mouth properly restored and pain free? |  |
| [ ] Y[ ] N | Does any type of dental treatment make you nervous? If yes, please explain below: |  |
|  |  |  |
| The most important concerns regarding my dental treatment are: |  |
|  |  |  |
| What factors are most important for your satisfaction with our office? |  |
|  |  |  |
| Any additional concerns/comments? |  |
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| Child/Minor Patients: Please answer the following questions: |
| [ ] Y[ ] N | Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.) |  |
|  |  |  |
| [ ] Y[ ] N | Any unusual speech habits? If yes, explain: |  |  |
| [ ] Y[ ] N | Any lost teeth? If yes, list: |  |  |
| [ ] Y[ ] N | Does the patient receive assistance with brushing and flossing? If yes, how often? |  |
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| **Medical History** |
| General Health: [ ] Excellent [ ] Good [ ] Fair [ ] Poor |
| [ ] Y[ ] N | Under a physician’s care now? |  |
| [ ] Y[ ] N | Any hospitalization in the past 5 years? |  |  |
| [ ] Y[ ] N | Any serious illnesses/surgeries? |  |  |
| [ ] Y[ ] N | Use tobacco in any form? If Yes, Type: |  |  |
| [ ] Y[ ] N | Is pre-medication required before dental visits due to heart condition or artificial joint? |  |
| [ ] Y[ ] N | Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.* |  |
| Female Patients: | [ ] Y[ ] N Currently nursing? | [ ] Y[ ] N Currently pregnant? | Due Date: |  |  |
|  |
| Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? [ ] Y[ ] NIf yes, please describe: |
|  |  |  |
|  |
| Is there anything important about your medical condition we have not asked? [ ] Y[ ] N If yes, please describe: |
|  |  |  |
|  |
| All Patients: Do you have, or have you ever had any of the following? (Check all that apply): | [ ] None |  |
| [ ] Acid Reflux | [ ] Bulimia | [ ] Hearing Problems | [ ] Psychiatric Treatment |
| [ ] ADHD | [ ] Cancer/Malignancy | [ ] Heart Attack | [ ] Radiation/Chemo |
| [ ] AIDS/HIV | [ ] Cerebral Palsy | [ ] Heart Disease | [ ] Respiratory Disease |
| [ ] Anemia | [ ] Chemical Dependency | [ ] Heart Murmur | [ ] Rheumatic Fever |
| [ ] Anorexia | [ ] Chicken Pox | [ ] Hepatitis | [ ] Sinus Problems |
| [ ] Anxiety | [ ] Convulsions | [ ] High Blood Pressure | [ ] Stroke |
| [ ] Artificial Heart Valve | [ ] Depression | [ ] Kidney Disease | [ ] Thyroid Condition |
| [ ] Artificial Joints | [ ] Diabetes | [ ] Liver Problems | [ ] Tuberculosis |
| [ ] Arthritis | [ ] Dizziness/Fainting | [ ] Mitral Valve Prolapse | [ ] Ulcers |
| [ ] Asthma | [ ] Epilepsy/Seizures | [ ] Mononucleosis | [ ] Venereal Disease |
| [ ] Autism/Asperger’s | [ ] Frequent Ear Infections | [ ] Pacemaker |  |
| [ ] Bleeding Disorder | [ ]  Frequent Headaches | [ ] Other – please list: |  |  |
|  |
| All Patients: Are you ALLERGIC to or have you ever had any reaction to the following? (Check all that apply): |
| [ ] Aspirin | [ ] Codeine | [ ] Lactose Intolerance | [ ] Sleeping Pills | [ ] None |  |
| [ ] Anesthetic – Local | [ ] Dairy | [ ] Metal Sensitivity | [ ] Sulfa Drugs |
| [ ] Barbiturates | [ ] Latex | [ ] Nitrous Oxide Sedation | [ ] Penicillin/Other Antibiotics |
| [ ] Other – please list: |  |  |
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| **medication information** |
| All Patients: Are you currently taking any of the following? (Check all that apply): | [ ] None |  |
| [ ] Antibiotics/Sulfa Drugs | [ ] Antihistamines/Allergy | [ ] Daily Aspirin | [ ] Blood pressure Medications |
| [ ] Blood thinners | [ ] Cancer/Chemo Medications | [ ] Cortisone/Steroids | [ ] Heart Medication/Digitalis |
| [ ] Insulin | [ ] Nitroglycerin | [ ] Oral Contraceptives | [ ] Osteoporosis Medications |
| [ ] Other Diabetic Medications | [ ] Recreational Drugs | [ ] Thyroid Medications | [ ] Tranquilizers |
| [ ] Other (please list below) |  |  |  |
| **Drug Name** | **Dosage** | **Reason Prescribed** |
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**By signing below, I certify that the information above is accurate and complete to the best of my knowledge.**

 **Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Financial Guidelines**

*We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.*

**Insurance**

**We accept all major dental insurance payments, however we may not be an in network provider for your plan**. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

* **We are in network for Delta Dental Premier, BlueCross /Blue Shield and Cigna.**
* **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.
* **Workers Compensation claims** will be filed for you. Please understand the carrier will assign a dollar amount that will be paid towards the claim, which may or may not cover the entire fee. Any amount not covered by the carrier, will be your responsibility.
* **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

**Payments**

* **Patient portion or** **patient co-pay is due at** **the time services are rendered** - unless prior financial arrangements have been made.
* **Payment Information:**
	+ All major credit cards are accepted (Visa, MasterCard, Discover)
	+ 10% Discount for our uninsured cash/check paying patients
	+ Various financing options with CareCredit®
* **Balances left over 90 days will incur an 18% or $10 minimum monthly finance charge.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

**Short Cancelled/ Missed Appointments**

* **Please give 48 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.
* **Short canceled or missed appointments** will be charged one dollar per minute of time allotted for your appointment.

 **By signing below I acknowledge I have read and understand the guidelines above.**

|  |  |
| --- | --- |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Patient consent- payment authorization – signature on file** |
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| To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.I hereby authorize payment directly to Dr. Rosales of the dental benefits otherwise payable to me.I hereby authorize Dr. Rosales to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. **By signing below, I acknowledge that I have read and understand the statements mentioned above.** Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |