DISTINCTIVE DENTAL CARE

GENERAL, COSMETIC & RESTORATIVE DENTISTRY

Patient Information

Confidential

(PLEASE PRINT)

DATE ____________________

NAME ____ BIRTHDATE __________ HOME PHONE ______________
FIRST MI LAST

ADDRESS ____ CITY ______________ STATE/ PROV. _______ ZIP/ P. C. __________

EMAIL ____ CELL PHONE ______________________________

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR
PATIENT/ GUARDIAN'S EMPLOYER ____ WORK PHONE ______________

BUSINESS ADDRESS ______________________________ CITY ______________ STATE/ PROV. _______ ZIP/ P.C. __________

SPOUSE OR
PARENT/GUARDIAN'S NAME ____________________ EMPLOYER ____________________ WORK PHONE ______________

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? ____

WHOM MAY WE THANK FOR REFERRING YOU? ____

PERSON TO CONTACT IN CASE OF AN EMERGENCY ______________________________ PHONE ______________

Dental Insurance Information

NAME OF INSURED ____ RELATIONSHIP TO PATIENT ______________

BIRTHDATE ______________ SS#/SIN ______________________ INS. ID# ______________

NAME OF EMPLOYER ________________________________ WORK PHONE ______________

INSURANCE COMPANY ____________________ GROUP # ____________________ PHONE # ______________

ADDRESS OF INS. CO. ______________________ CITY ______________ STATE/ PROV. _______ ZIP/ P. C. __________

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED ____ RELATIONSHIP TO PATIENT ______________

BIRTHDATE ______________ SS#/SIN ______________________ INS. ID# ______________

NAME OF EMPLOYER ________________________________ WORK PHONE ______________

INSURANCE COMPANY ____________________ GROUP # ____________________ PHONE # ______________

ADDRESS OF INS. CO. ______________________ CITY ______________ STATE/ PROV. _______ ZIP/ P. C. __________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. As required by the HIPAA privacy regulations, I have received a current copy of the "NOTICE OF PRIVACY PRACTICES" and the office has explained this document to my satisfaction.

X ____
Signature of patient (or parent/guardian if minor)

Patient Medical History

Physician ____________________ Office Phone ____________________ Date of Last Exam ____________________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain ____________________	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? ____________________	☐	☐
4. Do you use tobacco? If yes, how much? ____________________	☐	☐
5. Do you use controlled substances?	☐	☐
6. Are you wearing contact lenses?	☐	☐

8. Are you allergic to or have you had any reactions to the following:	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin, Sulfa or any other Antibiotics	☐	☐
Codeine	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other ____________________	☐	☐
9. Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Thyroid Problem	☐	☐	Stroke	☐	☐
Heart Attack	☐	☐	Heart Disease	☐	☐	Hay Fever/Allergies	☐	☐
Rheumatic Fever	☐	☐	Cardiac Pacemaker	☐	☐	Tuberculosis	☐	☐
Swollen Ankles	☐	☐	Heart Murmur	☐	☐	Radiation Therapy	☐	☐
Fainting/Seizures	☐	☐	Angina	☐	☐	Glaucoma	☐	☐
Asthma	☐	☐	Emphysema	☐	☐	Recent Weight Loss	☐	☐
Low Blood Pressure	☐	☐	Cancer	☐	☐	Liver Disease	☐	☐
Epilepsy/Convulsions	☐	☐	Arthritis	☐	☐	Heart Trouble	☐	☐
Leukemia	☐	☐	Joint Replacement or Implant	☐	☐	Respiratory Problems	☐	☐
Diabetes	☐	☐	Hepatitis/Jaundice	☐	☐	Other ____________	☐	☐
Kidney Diseases	☐	☐	Sexually Transmitted Disease	☐	☐			
AIDS or HIV Infection	☐	☐	Stomach Troubles/Ulcers	☐	☐			

Patient Dental History

Name of Previous Dentist and Location ____________________ Date of Last Exam ____________________

Does dental treatment make you nervous? No Slightly Moderately Extremely

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Have you had any orthodontic treatment?	☐	☐
11. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
12. Have you had a history of periodontal disease?	☐	☐
13. Do you require pre-medication prior to receiving dental treatment?	☐	☐

If I could change my smile I would make my teeth:	Yes	No	N/A
Whiter	☐	☐	☐
Straighter	☐	☐	☐
Close Space	☐	☐	☐
Replace black mercury fillings with tooth colored restorations	☐	☐	☐
Repair chipped teeth	☐	☐	☐
Replace missing teeth	☐	☐	☐
Less gum showing	☐	☐	☐
Replace old crowns or caps that don't match	☐	☐	☐

On a scale of 1 to 10, with 10 being the highest rating: (check one)

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 would you like your dental health to be?

1 2 3 4 5 6 7 8 9 10

Medical History Update

Any Changes? Yes No List ____________________ Initial __________ Date __________

Any Changes? Yes No List ____________________ Initial __________ Date __________

Any Changes? Yes No List ____________________ Initial __________ Date __________

Any Changes? Yes No List ____________________ Initial __________ Date __________

Any Changes? Yes No List Initial Date

Any Changes? Yes No List ____________________ Initial __________ Date __________

Financial Policy and Agreement

Thank you for choosing Distinctive Dental Care for your dental needs. We are committed to providing you with excellent care and convenient financial options. We realize you may be requiring some dental care and it is easy to forget that a doctor's office is also a small business. In the interest of both good medicine and good business, we believe it is best to establish a policy to avoid any misunderstandings later. As a result, we have developed this policy.

Please read, sign and return the following:

Payment:

Payment for service is due at the time services are provided unless other **payment arrangements** have been approved in advance. We accept cash, check, bank debit and all credit cards EXCEPT American Express. You might also be interested in taking advantage of one of our financing options we have available through third-party financing. By utilizing this wonderful finance option, your entire family will enjoy the excellent treatment we provide with minimum easy-to-budget monthly payments. They offer a variety of ***INTEREST FREE*** financing including plans with 6 and 12 month options.

Insurance:

Although we are contracted with **Delta Dental, Aetna and Cigna Dental PPO** only, we are "insurance friendly" and happy to process your insurance claim as a courtesy to you. While each policy is different, most plans cover 80%-100% of routine care (cleanings, x-rays, exams, ect.) and 50% of major work (filings, crowns, ect.). Please understand we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts. We ask that you pay your estimated portion on the day services are rendered. Any charges not covered by your insurance are your responsibility. We will allow 45 days for your insurance carrier to render payment. After 60 days, you are responsible for the remaining balance in full. We must emphasize that as health care providers our relationship is with you, our patient, not with your insurance company. This office cannot accept responsibility for negotiating a settlement on a disputed claim. However, we are experienced with processing insurance claims and proactively send information along with your claim which carriers typically require. Our goal is to assist you with processing your claim in a timely manner and utilize your benefits to the fullest.

Missed or Cancelled Appointments:

Once an appointment has been made, please remember that this time has been reserved specifically for you. We reserve the right to **charge a fee for all cancelled or missed appointments without 24 hour notice.**

Timeliness and Communication:

We are committed to seeing you on-time and request you are on-time for your visits as well. This way, we can ensure all our patients are seen when promised. As it relates to communications, we request you give us permission to tell you exactly what is happening with your dental condition and explain how to best treat that condition(s).

I understand and agree to this Financial Policy and Agreement:

____ ______________

Signature of patient/responsible party Date