Date: _____ Patient Name:_____

_____

Date of Birth: _____ SS # _____ Male _____ Female _____

Marital Status: Single _____Married _____Separated _____Divorced _____Widowed_____

Home Address: _____ City: _____State: _____ Zip: _____

Home # _____ Cell # _____ Work # _____

Email Address_____ (For Appointments)

Preferred way to be Contacted: Text _____ Email _____ Phone Call_____

If patient is a minor, who is legally responsible? _____

Relationship _____ Phone # _____

In case of Emergency, who should we contact? _____

Emergency # _____ Relationship: _____

Were you referred, If Yes who may we thank?

_____

How did you hear about us: Google _____Flyer _____ Community Event_____ FaceBook_____ Other_____

Insurance Information:

Do you have Insurance for us to bill for you today: Yes _____ No_____

Subscriber's Name:_____Subscriber'sEmployer:_____

Name of Insurance Co: _____ Insurance Phone #: _____

Date of Birth: _____ SS# _____ Subscribers ID # _____

Group # _____Relationship to Subscriber: _____

Does patient have a **Secondary** insurance? Yes _____ No _____

Subscriber's Name: _____Subscriber's Employer: _____

Name of Insurance Co: _____Insurance Phone #: _____

Date of Birth: _____SS# _____Subscribers ID # _____

Group # _____Relationship to Subscriber: _____

** I hereby authorize payment of the dental and insurance benefits and authorize the release of dental information to my insurance company in order for claims to be processed. I have received and signed the financial policy.

_____ _____

Patient or Guardian Signature Date

Name:_____

Are you under medical treatment now? No or yes
If so, please explain: _____ Treating Physician name and #: _____
Have you ever been hospitalized for any surgery or serious illnesses? Yes _____ No_____ If yes, what?_____

Have you ever taken any Bisphosphonate drugs such as Fosamax, Actonel, Boniva, or Reclast? Yes _____ No _____
Have you ever taken Fen-Phen (Phentermine)? Yes _____ No_____ Do you need to Pre Med? Yes _____ No_____

MEDICATIONS

Are you currently taking medications? Yes_____ No_____

If yes, what and what for:

_____

MEDICAL CONDITIONS

___ Hepatitis, Type:_____ ___ Arthritis ___ Psychiatric/Psychological care ___ neurological
___ Kidney Disease ___ Glaucoma ___ Heart Murmur/Pacemaker ___ Tobacco User
___ Fainting ___ Chest Pains ___ Epilepsy/Convulsions ___ Drug/Alcohol Abuse
___ High Blood pressure ___ Low Blood Pressure ___ HIV/Aids positive ___Chemotherapy
___ Stroke, Yr.___ ___ Herpes Simplex I or II ___ Cold Sores ___ Latex Sensitivity
___Tuberculosis ___ Gout ___ Radiation___ ___ Asthma/Respiratory
___ Hay Fever/Allergies ___ Venereal Disease ___Diabetes, Which Type:___ ___ Rheumatic Fever
___ Thyroid Problems ___Dental Anxiety ___ Heart Attack/Surgery/disease, Yr___ ___ Cancer,type and Yr._____
___Leukemia/Anemia/Blood Disorder Other:_____

___Full/Partial Joint Replacement If yes, When?_____ Which Joint?_____

Are you Pregnant/Breastfeeding? Yes ___ No___ Are you taking birth control? Yes ___ No___

ALLERGIES:

___ Aspirin/Ibuprofen ___ Penicillin ___ Sulfa ___ Codeine ___ Sedative ___ Iodine ___ Latex ___ Local Anesthetic
Other: _____

PATIENT DENTAL HISTORY

When was your last dental visit? _____ Name of previous Dentist?_____

Dental History:

Yes ___ No ___ Are you having pain/discomfort as this time?
Yes ___ No ___ Do you clench or grind your teeth?
Yes___ No___ Teeth or Fillings breaking?

What would you like to improve?

Whiten _____ Replace missing teeth _____
Straighten _____ Replace missing teeth _____
Close spaces _____ Repair chipped teeth_____
Replace oldcrowns_____

** 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 may be detrimental to my health.

Patient /Guardian signature_____ Date_____

Thank you for choosing Deluxe Dental as your dental care provider!

Our professional dental team is committed to providing you excellent dental care in a friendly, comfortable setting. The following is a statement of our financial policy, which we request that you read and sign prior to treatment.

Full payment is due at the time of service, unless other arrangement has been made. We accept cash, check, debit card, Visa, MasterCard, Discover, American Express and Carecredit. Interest on balance unpaid beyond 90 days will be applied at the rate of 1.5% monthly (18% annually).

While we do accept assignment of insurance benefits, your portion of each service is due at the time services are rendered. This may be based on an **estimate** of insurance payment, not a guarantee of payment. Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. We do, however, submit dental claims as a courtesy to our patients and will do our best to assist you in understanding and applying your dental benefits. We cannot guarantee insurance payments or payment amounts. All treatment estimates are provided based upon information from your insurance company and are estimates only. If your insurance company has not paid your account in full within 90 days of billing, we will require the balance to be paid directly by you via cash, check, debit or credit cards.

Treatment plan are created based upon clinical findings during your diagnostic exam and are subject to change based upon clinical need and/or our treatment schedule.

Our policy is to charge for missed appointments or appointments that are not cancelled less than a **24 hour notice** at the rate of **$25.00** per appointment. Please help us serve you better by keeping scheduled appointments.

Return checks are subject to an additional fee of **$25.00**.

Unpaid balances are subject to action by a collection agency.

Signature on File

By signing below, I give my permission for Deluxe Dental to release necessary information regarding my treatment to by insurance company(s) and assign dental benefit payments directly to Deluxe Dental.

If you have any further questions regarding our financial policy, please ask a member of our dental team.

I UNDERSTAND AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY.

Print Patient Name: _____ Date: _____

Patient/Guardian Signature: _____ Relationship to Patient: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

(Please Initial one of the following)

**** I have received a copy of this office's notice of Privacy Practices _____**

**** I have reviewed the notice of Privacy Practices, but declined my copy _____**

Print Patient Name: _____ Date:_____

Patient/Guardian Signature:_____ **Relationship to**

Patient:_____

We attempted to obtain written acknowledgement of receipt of our notice of Privacy Practices, but acknowledgement could not be obtained because:

- **Individual refused to sign**
- **Communication barriers prohibited obtaining acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgment**
- **Other (please specify): _____**

Employee Signature: _____ Date: _____