

Patient Information

Patient Name: _____ Date of Birth: _____
Last First MI
Address: _____
Street Apartment #
City State Zip Code

Social Security #: _____ Male Female Married Single Child Other _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____
EMAIL Address _____

Medical History

Primary Physician's Name _____ Physician's Phone # _____ Last Exam Date _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> AIDS/HIV + | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tobacco Habit:
_____/ppd; ____ years |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood/Bleeding Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis (Type _____) | Due date: _____ | <input type="checkbox"/> Height _____ |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> High Blood Pressure | Birth Control: Yes No | <input type="checkbox"/> Weight _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hospitalized Last 2 yrs | <input type="checkbox"/> Respiratory Disease | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever | |

All those checked, Please explain

Medication

List medications you are currently taking: _____

Allergies

List any allergies you have: _____

Dental History

Reason for today's visit: _____

Former Dentist: _____ Why did you change dental offices? _____

Date of Last Dental Visit: _____ Date of last dental x-rays _____ How often do you brush? _____ Floss? _____

Do you like the appearance of your teeth? _____

Circle if you have or have had any of the following:

- | | | | |
|----------------------------------|-------------------------------------|-----------------------------|--------------------------|
| Bad Breath | Food collection between teeth | Loose teeth/broken fillings | Sensitivity to heat/cold |
| Bleeding Gums | Grinding teeth | Mouth sores or growths | Sensitivity to sweets |
| Clicking, popping or pain in Jaw | Habits (nail, pen biting, gum, etc) | Periodontal Treatment | Sensitivity when biting |

Do you have any medical or dental problems that need further clarification? Yes No

If yes, please explain: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the medical/dental conditions above have been answered to my satisfaction. I will not hold my dentist, dental hygienist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. I will always inform the doctor or staff of any changes to my health at my next appointment without fail.

Date: _____

Signature of patient, parent or guardian _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative Dental Office

Yellow Pages Newspaper Work Road Sign Publication, please specify: _____

Name of person or office referring you to our practice so they may receive their *Referral Discount* _____

Spouse or Responsible Party Information

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Insurance Information

Primary Dental Insurance Information

Insured Name: _____ Relation to Patient _____
Insured Address: _____
S.S.#: _____ DOB: _____ Group/Plan ID# _____
Insur. Co. Name _____ Tel #: (____) _____
Insur. Co. Address _____
Employer: _____

Secondary Dental Insurance Information

Insured Name: _____ Relation to Patient _____
Insured Address: _____
S.S.#: _____ DOB: _____ Group/Plan ID# _____
Insur. Co. Name _____ Tel #: (____) _____
Insur. Co. Address _____
Employer: _____

Financial & Insurance Information

For your convenience we accept Visa, MasterCard, Discover and American Express. We deliver the finest care at a reasonable cost to our patients, therefore payment is due at the time service is rendered unless other arrangements have been made in advance. If you have questions regarding your account, please contact us. Many times, a simple telephone call will clear up any misunderstandings.

We will send you a monthly statement. Most insurance companies will respond within four to six weeks. Please call our office if your statement does not reflect your insurance payment within that time frame. Your prompt remittance is appreciated. We offer a MONTHLY PAYMENT PLAN in the office via *Care Credit* (ask for details) which can be interest free up to 12 months if you qualify.

Here at our office, we try to maximize your dental insurance benefits. Keep in mind, I do not believe that it is in either of our best interests for me to compromise my recommended treatment, in order to accommodate dental insurance. Also, keep in mind that we will fill your insurance claims as a *courtesy* but this does not guarantee payment by the insurance company. You are ultimately responsible of your bill regardless of coverage. It is your responsibility to be informed about eligibility and coverage. **REMEMBER, we are only estimating your portion the day of treatment. You will receive a statement for remainder of the balance when insurance payment has been received.** All outstanding balances past 30 days are subject to a 1 ½ % service charge, unless previously written financial arrangement are satisfied. After 90 days, you will be given a final notice before being turned over to a collection agency. Please remember you are fully responsible for all fees for services provided by our office regardless of your insurance coverage.

I have read the above and fully understand it's content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Consent for Services

I hereby authorize and direct Dr. Capehart and/or dental team of his choice, to perform the full scope of general dentistry on the patient. I understand there are risks in all treatments and hereby acknowledge that these risk(s) will be explained to me. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the doctor. I also authorize the doctor to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

I have read the above conditions and agree to the Consent of Services.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

OFFICE POLICY ON BROKEN APPOINTMENTS

Please be on notice that there will be an additional charge for no-shows and broken appointments with less than 24 hour notice. We enacted the policy in order to be fair to all patients.

I have read the Broken Appointment policy above and signed below that I understand the policy.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____