



Date

1. Patient's Name Last First Middle Driver's Licence #
2. Address Street City State Zip Code
3. Home Phone Birth Date Social Security #
4. E-mail Address Cell Phone Work Phone

5. Person Responsible for Payment Last First Middle
6. Address Street City State Zip Code
7. Relationship to Patient
8. Social Security #
9. Birth Date
10. Driver's Licence #
11. Home Phone
12. Employer
13. Work Phone

If minor, list parent's names:
Father First Last
Mother First Last

14. Patient's Spouse Name Last First Middle
15. Spouse's Employer
16. Occupation
17. Work Phone

DENTAL INSURANCE INFORMATION (need copy of card)
18. Insured's Name
19. Insured's Birth Date
20. Insured's Address (if different from above)
21. Insured's Social Security #
22. Insured's Employer
23. Insurance Company Name Group Name
24. Insurance Address

EMERGENCY INFORMATION
25. Local Friend or Relative not living with you
26. Complete Address
27. Phone Number

GETTING TO KNOW YOU
28. Why did you select our office?
29. Whom may we thank for referring you?
30. Is another member of your family or relative a patient in our practice?

FOR ALL PATIENTS
I authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistants as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

PRIVACY POLICY
I have chosen NOT to receive a copy of the privacy policy. I understand a copy is available at any time.

Patient's, Parent's or Guardian's Signature

Date

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

HAVE YOU EVER HAD THE FOLLOWING:

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. hospitalization for illness or injury..... | <input type="checkbox"/> | <input type="checkbox"/> | 25. digestive disorders..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. allergic reaction to | | | 26. arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen | | | 27. glaucoma..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> penicillin | | | 28. contact lens..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> erythromycin | | | 29. head or neck injuries | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> codeine | | | 30. epilepsy, convulsions (seizures)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> local anesthetic | | | 31. viral infections and cold sores..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fluoride | | | 32. any lumps or swelling in the mouth | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> metals (gold, stainless steel) | | | 33. hives, rash, seasonal allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> latex | | | 34. venereal disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> any other medications..... | | | 35. hepatitis (type____)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems..... | <input type="checkbox"/> | <input type="checkbox"/> | 36. HIV / AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. heart murmur..... | <input type="checkbox"/> | <input type="checkbox"/> | 37. tumor, abnormal growth | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | 38. radiation therapy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. scarlet fever | <input type="checkbox"/> | <input type="checkbox"/> | 39. chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. high blood pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | 40. emotional problems, nervousness..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | 41. psychiatric treatment..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. a stroke | <input type="checkbox"/> | <input type="checkbox"/> | 42. antidepressant medication | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. artificial prosthesis (i.e. heart valve or joints) | <input type="checkbox"/> | <input type="checkbox"/> | 43. alcohol / drug dependency | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. anemia or other blood disorder | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 12. prolonged bleeding due to a slight cut..... | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU: | | |
| 13. emphysema..... | <input type="checkbox"/> | <input type="checkbox"/> | 44. presently being treated for any other illness | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. tuberculosis..... | <input type="checkbox"/> | <input type="checkbox"/> | 45. aware of any change in your general health | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. asthma..... | <input type="checkbox"/> | <input type="checkbox"/> | 46. taking medication for osteoporosis/osteopenia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. sinus problems | <input type="checkbox"/> | <input type="checkbox"/> | 47. often exhausted or fatigued | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | 48. subject to frequent headaches..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. liver disease..... | <input type="checkbox"/> | <input type="checkbox"/> | 49. a heavy smoker (1 pack or more a day) | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. jaundice | <input type="checkbox"/> | <input type="checkbox"/> | 50. considered a touchy person..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. thyroid or parathyroid disease..... | <input type="checkbox"/> | <input type="checkbox"/> | 51. often unhappy or depressed..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. hormone deficiency | <input type="checkbox"/> | <input type="checkbox"/> | 52. easily upset or irritated..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. high cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | 53. FEMALE: taking birth control pills | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. diabetes | <input type="checkbox"/> | <input type="checkbox"/> | 54. FEMALE: pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. stomach or duodenal ulcer..... | <input type="checkbox"/> | <input type="checkbox"/> | 55. MALE: prostate disorders | <input type="checkbox"/> | <input type="checkbox"/> |

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment

List any medications, supplements, and or vitamins taken within the last two years

DRUG	PURPOSE	DRUG	PURPOSE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



DENTAL HISTORY

How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____ / ____ / ____ Date of most recent x-rays ____ / ____ / ____

Date of most recent treatment (other than cleaning) ____ / ____ / ____

I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

- 1. Are you fearful of dental treatment? Scale of 1 to 10 (very)
2. Have you ever had an unfavorable dental visit?.....
3. Have you ever had complications from past dental treatment?
4. Have you ever had trouble getting numb or reactions to local anesthetic?
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?
6. Have you had any teeth removed?

SMILE CHARACTERISTICS

- 7. Is there anything about the appearance of your teeth that you would like to change?
8. Have you ever whitened (bleached) your teeth?
9. Are you self-conscious about your teeth?
10. Have you been disappointed with the appearance of previous dental work?

BITE AND JAW JOINT

- 11. Do you / would you have any problems chewing gum?
12. Do you / would you have any problems with chewing bagels or other hard food?.....
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?
14. Are your teeth crowding or developing spaces?
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?.....
16. Do you have any problems with sleep or wake up with an awareness of your teeth?
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, or popping)
18. Do you have tension headaches or sore teeth?
19. Do you wear or have you ever worn a bite appliance?

TOOTH STRUCTURE

- 20. Have you had any cavities within the past 3 years?
21. Do you have a dry mouth?
22. Are any of your teeth sensitive to hot, cold, biting or sweets?.....
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?
24. Do you avoid brushing any part of your mouth?

GUM AND BONE

- 25. Have you ever been diagnosed or treated for periodontal (gum) disease?
26. Have you ever experienced gum recession?
27. Is there anyone with a history of periodontal disease in your family?
28. Do your gums bleed when brushing, flossing or eating?.....
29. Are your teeth becoming loose?
30. Have you ever noticed an unpleasant taste or odor in your mouth?
31. Have you ever experienced a burning sensation in your mouth?

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



Our Financial Policy

Thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you. As you know, our office and health care providers continue to struggle trying to get insurance companies to pay us in a timely manner. In order for us to provide the best service possible, we find ourselves having to make some hard insurance decisions. As a result, we implemented a new Financial Policy, which we require that you read, and sign prior to any treatment.

INSURANCE COVERAGE

Our office is happy to cooperate with patients who are covered by dental insurance. We ask that you familiarize yourself with your policy and be aware of any limitations that might exist. Having dental insurance means that you have an agreement with your insurance company regarding payment for dental procedures. There are varying dental levels that are available with a given insurance company. How well your plan pays will be based on what level plan of insurance you have purchased. We will file your primary insurance claim for you to help you obtain the reimbursement with which you are entitled. If your insurance company does not cover all costs, it will become **your responsibility** to make final payment.

PAYMENTS

Payment is due at time of service less your estimated insurance benefit. You may use cash, check, credit card or debit card to pay. Payment arrangements may be requested in cases of financial hardship through Care Credit. Except when financial arrangements have been made before hand, accounts that are 60 days past due will be billed 1.5% interest on the total unpaid balance. Accounts that are 90 days past due will be referred to a third-party collection agency.

INSURANCE PAYMENTS

Your insurance is a contract between you and your insurance company. We are not a party in this contract. Be assured, our office works diligently to obtain payment from your insurance company. **However, if we file your insurance, and the claim has not been paid for any reason within 60 days, we require that you pay the balance using one of the approved payment methods without exception.** In the event that your insurance pays us after that time, you will be reimbursed.

CONSENT FOR PROCEDURE

I certify that all of the medical and dental information I have provided is true and accurate to my knowledge and I have not eliminated any pertinent information. I consent to the performing of any dental examinations and treatment procedures agreed to be necessary or advisable, including anesthesia, nitrous oxide, or oral sedation, as indicated. A separate consent will be obtained for any surgical procedures. I understand that I will be informed of any treatment changes as they occur. I also understand that I am responsible for all fees associated with all procedures and all costs incurred in the collection of those fees, even if I am covered under a dental insurance policy.

EMERGENCY FIRST-TIME VISITS

Emergency first-time visits, we require payment in full of either cash or credit card prior to being seen.

MISSED/LATE-CANCELLED APPOINTMENTS

Our office requires a 24-hour notice for any rescheduling or cancellation of appointments. An appointment which is cancelled or failed without 24-business-hour notice will allow our office to charge a **\$75.00 broken appointment fee.** Please note our business hours are ***Monday – Thursday 8am to 5pm and Fridays 8:30 to 12:30.***

RETURNED CHECKS

Our bank charges us whenever a patient presents a check that does not have funds available. Therefore, we must charge you a **\$35.00** handling fee. Payment plus the handling fee will be due immediately, and we will request that future visits be paid with cash, credit or debit card. We welcome the opportunity to discuss any aspect of our financial policy. **Please** ask to speak to our office manager or assistant manager if you have any questions, comments, or concerns. We sincerely regret having to create such a policy and hope you understand our reasoning. We thank you for your support, and look forward to serving you in the future.

PATIENT AUTHORIZATION

I have read, understand, and agree to abide by the terms stipulated above. I request that payment of benefits be made to Matthew Horne, DDS. I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim. This authorization shall remain valid until revoked by me in writing.

Patient Name _____

Patient Signature (or Parent of minor/Legal Guardian): **X** _____ Date: _____

Name of person completing form if other than patient: _____ Relation: _____