



PATIENT INFORMATION

Name (Mr., Mrs., Ms., Dr.,) _____
Last First Middle

Residence/Address _____ City _____ Zip _____

Business/Address _____ City _____ Zip _____

Home Phone # _____ Business Phone # _____

Cell Phone # _____ E-mail Address _____

Date of Birth ____/____/____ Social Security # _____

If patient is a minor, Name of mother and father _____

Place of Employment _____

Occupation/Former Occupation _____

SPOUSE INFORMATION

Name _____ Date of Birth ____/____/____

Employer _____ Occupation _____

In Case of Emergency

Person to Contact _____ Phone # _____

Friend/Relative Not Living with Patient _____ Phone # _____

REFERRAL SOURCE

Whom may we thank for referring you? _____

If not referred, how did you hear about us? _____

RESPONSIBLE PARTY (If Other Than Self)

Person Responsible for Payment of Account _____ Relationship _____

Mailing Address _____ City _____ State _____

Date of Birth ____/____/____ Phone # _____ Zip _____

INSURANCE INFORMATION

Name of Primary Dental Insurance Plan _____

Policy or Group # _____ Subscriber's Name (if different) _____ SSN of Subscriber _____

Name of Secondary Dental Insurance Plan _____

Policy or Group # _____ Subscriber's Name (if different) _____ SSN of Subscriber _____

There will be a charge for broken appointment without 72 hours notice. I understand that responsibly for payment for dental services provided in this office for myself or my dependent is mine, regardless of insurance benefits. I also understand that payment is due and payable at the time services are rendered. A finance charge will be added, if payment is not received within 90 days of service. I realize that failure to keep this account current may result in you being unable to provide additional dental services.

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. 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 (10 being very)			
2. Have you had an unfavorable dental experience?			
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 chewing bagels or other hard foods?			
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?			
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 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 _____

MEDICAL HISTORY

Patient Name _____ Preferred Name _____ 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	HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. hospitalization for illness or injury			22. diabetes		
2. heart problems			23. stomach or duodenal ulcer		
3. heart murmur			24. digestive disorders		
4. rheumatic fever			25. arthritis		
5. scarlet fever			26. glaucoma		
6. high blood pressure			27. contact lenses		
7. low blood pressure			28. head or neck injuries		
8. a stroke			29. epilepsy, convulsions (seizures)		
9. artificial prosthesis (i.e. heart valve or joints)			30. neurological problems		
10. anemia or other blood disorder			31. viral infections and cold sores		
11. prolonged bleeding due to a slight cut			32. any lumps or swelling in the mouth		
12. emphysema			33. hives, skin rash, hay fever		
13. tuberculosis			34. venereal disease		
14. asthma			35. hepatitis (type _____)		
15. sinus problems			36. HIV / AIDS		
16. kidney disease			37. tumor, abnormal growth		
17. liver disease			38. radiation therapy		
18. jaundice			39. chemotherapy		
19. thyroid or parathyroid disease			40. psychiatric treatment / emotional problems		
20. hormone deficiency			41. antidepressant medication		
21. high cholesterol			42. alcohol / drug dependency		

ARE YOU:	YES	NO	Have you ever had an allergic reaction to:	YES	NO
1. presently being treated for any other illness			1. aspirin, ibuprofen, acetaminophen		
2. aware of any change in your general health			2. penicillin		
3. on medication for osteoporosis/osteopenia			3. erythromycin		
4. often exhausted or fatigued			4. tetracycline		
5. subject to frequent headaches			5. codeine		
6. a smoker or smoked previously			6. local anesthetic		
7. considered a touchy person			7. fluoride		
8. often unhappy or depressed			8. metals (gold, stainless steel)		
9. FEMALE – taking birth control pills			9. sulfa drugs		
10. FEMALE – pregnant			10. latex		
11. MALE – prostate disorders			11. any other medications _____		

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

Please 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 ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



Update #1 - Since your last visit have you:	Update #2 - Since your last visit have you:	Update #3 - Since your last visit have you:
1. seen a medical doctor?	1. seen a medical doctor?	1. seen a medical doctor?
2. had a change in your medication?	2. had a change in your medication?	2. had a change in your medication?
3. had a change in your medical condition?	3. had a change in your medical condition?	3. had a change in your medical condition?
4. had surgery?	4. had surgery?	4. had surgery?
Date _____ Signature _____	Date _____ Signature _____	Date _____ Signature _____

CONSENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor and mutually agreed upon, for the purposes of diagnosis or educational presentation.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.
3. I consent to the use of appropriate medication and therapy deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf and that of my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1½% finance charge (18% APR) may be added to my account.

Patient _____ Date ____ / ____ / ____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the physician, dentist, or other health care provider to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate, or evaluate any claim for benefit.

If my coverage is under a group master agreement held by my employer, and association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall remain effective for up to five years from this date.

Patient _____ Date ____ / ____ / ____

Parent or Responsible Party _____

AUTHORIZATION FOR SUBMISSION OF CLAIMS & ASSIGNMENT OF BENEFITS

I authorize the office of New Image Dental to submit claims for payment for services to my health care service plans or insurance companies on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

Patient _____ Date ____ / ____ / ____

Parent or Responsible Party _____

I understand that New Image Dental will make every effort possible to assist me with my insurance coverage. New Image Dental allows no more than 90 days for the insurance to submit payment. Any outstanding claims past the 90-day mark will be my responsibility. If the insurance submits a payment following the deadline, New Image Dental will reimburse me or credit my account. It is my responsibility to pay any deductible, co-payment, or any other balance not paid by my insurance company. New Image Dental requires my estimated portion at the time treatment is rendered.

CANCELLATION

I understand that should I need to cancel an appointment time reserved specifically for me, I will notify the dental office at least 72 hours in advance so that my time may be utilized by another patient. If I fail to give a minimum of 72 hours notice, I will either be required to pay a fee of \$50 per scheduled hour before a new appointment time will be made for me, or be put on a short call list.

Patient _____ Date ____ / ____ / ____

Parent or Responsible Party _____

I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way.

Patient refused / was unable to sign because _____

I have received a copy of the **DENTAL MATERIALS FACT SHEET** as required by law.

Patient _____ Date ____ / ____ / ____

Parent or Responsible Party _____

